HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
OCTOBER 25, 2017
APPLICATION SUMMARY

NAME OF PROJECT:	StoneCrest Surgery Center
PROJECT NUMBER:	CN1707-023
ADDRESS:	Unaddressed site within the campus of StoneCrest Medical Center (200 StoneCrest Blvd) Smyrna (Rutherford County), TN 37167
LEGAL OWNER:	StoneCrest Surgery Center, LLC One Park Plaza Nashville (Davidson County), TN 37203
OPERATING ENTITY:	Medical Care America, LLC 13355 Noel Road, Suite 650 Dallas (Dallas County), TX 75240
CONTACT PERSON:	John Wellborn (615) 665-2022
DATE FILED:	July 25, 2017
PROJECT COST:	$10,556,553
FINANCING:	Cash Transfer from Parent Company
REASON FOR FILING:	Establishment of a Multi-Specialty ASTC

DESCRIPTION:

StoneCrest Surgery Center, LLC, is seeking approval to establish a multi-specialty ambulatory surgery treatment center (ASTC) with two operating rooms and one procedure room located at an unaddressed site within the campus of StoneCrest Medical Center located at 200 StoneCrest Boulevard, Smyrna Boulevard, (Rutherford County), TN 37167. The project will involves the construction of 13,000 square feet of new ASTC space that will be leased by the applicant.

Note to Agency Members: Saint Thomas Surgery Center New Salem, LLC, CN1707-022, will also be heard simultaneously at the October 25, 2017 Agency Meeting with StoneCrest Surgery Center, CN1707-023. Saint Thomas Surgery Center New Salem, LLC, CN1707-022 is for the establishment of a multispecialty ambulatory surgery treatment center (ASTC) with two operating rooms and one procedure room located at 2779 New Salem Road, Murfreesboro (Rutherford County), TN 37128. The project will involve the construction of 13,000 square feet of new leased ASTC space. Saint Thomas Surgery Center New Salem, LLC, CN1707-022 projects 90% of patients will originate from the following areas: 9 Zip Codes in Rutherford County (60.8%), 2 Zip Codes in Coffee County (8.9%), 1 ZIP Code in Warren County (3.9%), 1 ZIP Code in Bedford County (5.0%), and 8.6% from other ZIP codes each representing under 1.3% from all 5 counties in the proposed service area.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW

Ambulatory Surgical Treatment Centers (*Revised May 23, 2013*)

The following apply:

1. Need. The minimum numbers of 884 Cases per Operating Room and 1867 Cases per Procedure Room are to be considered as baseline numbers for purposes of determining Need.[2] An applicant should demonstrate the ability to perform a minimum of 884 Cases per Operating Room and/or 1867 Cases per Procedure Room per year, except that an applicant may provide information on its projected case types and its assumptions of estimated average time and clean up and preparation time per Case if this information differs significantly from the above-stated assumptions. It is recognized that an ASTC may provide a variety of services/Cases and that as a result the estimated average time and clean up and preparation time for such services/Cases may not meet the minimum numbers set forth herein. It is also recognized that an applicant applying for an ASTC Operating Room(s) may apply for a Procedure Room, although the anticipated utilization of that Procedure Room may not meet the base guidelines contained here. Specific reasoning and explanation for the inclusion in a CON application of such a Procedure Room must be provided. An applicant that desires to limit its Cases to a specific type or types should apply for a Specialty ASTC.

   The applicant is projecting 725 cases per operating room (OR) and 500 per procedure room (PR) in Year One (2020). In Year One the applicant will not

meet the above minimum requirement of 884 cases per operating room and 1,867 cases per procedure room.

The applicant indicates the proposed procedure room will not meet the base utilization guidelines but is needed for gastroenterology endoscopy procedures, which are nonsterile surgeries not appropriate to mix with cases requiring a sterile OR.

It appears that this criterion has not been met.

2. Need and Economic Efficiencies. An applicant must estimate the projected surgical hours to be utilized per year for two years based on the types of surgeries to be performed, including the preparation time between surgeries. Detailed support for estimates must be provided.

Based on an average of 50 minutes per operating room case plus 15 minutes for turnover/prep, the operating room projected surgical hours will be 15.55 hours per week/OR or 809 hours in Year Two. The hours for Year Two are approximately equal to 40.5% of total schedulable hours.

Based on an average of 20 total minutes per case, plus 7 minutes for turnover/prep, the projected procedure room surgical hours will be 4.45 hours per week or 232 hours in Year Two. The hours for Year Two are approximately equal to 11.6% of total schedulable hours.

The applicant provided a table in Supplemental #1 detailing the projected surgical hours and preparation time between surgeries in Year Two.

It appears this criterion has been met.

3. Need; Economic Efficiencies; Access. To determine current utilization and need, an applicant should take into account both the availability and utilization of either: a) all existing outpatient Operating Rooms and Procedure Rooms in a Service Area, including physician office based surgery rooms (when those data are officially reported and available[3]) OR b) all existing comparable outpatient Operating Rooms and Procedure Rooms based on the type of Cases to be performed. Additionally, applications should provide similar information on the availability of nearby out-of-state existing outpatient Operating Rooms and Procedure Rooms, if that data are available, and provide the source of that data. Unstaffed dedicated outpatient Operating Rooms and unstaffed dedicated outpatient Procedure Rooms are considered

available for ambulatory surgery and are to be included in the inventory and in the measure of capacity.

There are 2 single-specialty and 4 multi-specialty ASTCs in the proposed service area. The applicant has provided a 2016 utilization table of all single and multi-specialty ASTCs operating in the proposed service area on page 36R3 of the application.

It appears this criterion has been met.

4. Need and Economic Efficiencies. An applicant must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON application to establish an ASTC or to expand existing services of an ASTC should not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed, if those services are known and relevant, within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above.

Note to Agency members:

For a dedicated outpatient operating room:

- ***Full Capacity is defined as 1,263 cases per year.***
- ***Optimum Capacity is defined as 70% of full capacity, or 884 cases per year.***

For a dedicated outpatient procedure room:

- ***Full Capacity is defined as 2,667 cases per year.***
- ***Optimum capacity is defined as 70% of full capacity, or 1,867 cases per year.***

There are a total of two single-specialty ASTCs in the proposed 3 county 10 ZIP code service area. The service area single-specialty ASTCs representing 1 operating room (OR) and 1 procedure room (PR) provided 44 OR cases and 2,395 PR cases in 2016, 5.0% of the OR and 128.3% of the PR optimum utilization standard. Please refer to the following table.

Single Specialty ASTC Operating and Procedure Room 2016 Utilization in the proposed Service Area

ASTC	County	# ORs/PRs	# Cases per OR	# Cases per PR	% of meeting Optimum Standard	
					884 per OR	1,867 per PR
Williams Surgery Center (Podiatry)	Rutherford	1/0	44	0	5.0%	n/a
Mid-State Endoscopy Center	Rutherford	0/1	0	2,395	N/A	128.3%
Total		**1/1**	**44**	**2,395**	**5.0%**	**128.3%**

Source: Tennessee Department of Health, Division of Health Statistics, 2016 Joint Annual Reports

There are a total of four multi-specialty ASTCs in the proposed 3 county 10 ZIP code service area. The service area multi-specialty ASTCs representing 15 operating rooms (ORs) and 5 procedure rooms (PRs) provided 14,663 OR cases and 7,664 PR cases in 2016, and averaged 978 cases or 111% of the OR and 82% of the PR optimum utilization standard. Please refer to the table below.

Multi-Specialty ASTC Operating and Procedure Room 2016 Utilization in the proposed Service Area

ASTC	County	# ORs/PRs	# Cases per OR	# Cases per PR	% of meeting Optimum Standard	
					884 per OR	1,867 per PR
Middle Tennessee Ambulatory Surgery Center	Rutherford	6/1	1,035	934	117.2%	50%
Physicians Pavilion Surgery Center	Rutherford	4/1	546	694	61.8%	37.2%
Surgicare of Murfreesboro Med Clinic	Rutherford	3/3	1,412	2,012	160%	107.8%
Premier Orthopedic Center	Rutherford	2/0	1,015	0	115%	N/A
Total		**15/5**	**978**	**1,532**	**111%**	**82%**

Source: Tennessee Department of Health, Division of Health Statistics, 2016 Joint Annual Reports

It appears that this criterion has been partially met for the following reasons:

- *The 884 per OR standard for the single-specialty ASTCs in the proposed service area was 5.0% and did not meet the OR optimum standard benchmark.*
- *The 1,867 per PR optimum standard for the proposed multi-specialty ASTCs in the proposed service area was 82% and did not meet the PR optimum standard benchmark.*

5. Need and Economic Efficiencies. An application for a Specialty ASTC should present its projections for the total number of cases based on its own calculations for the projected length of time per type of case, and shall provide any local, regional, or national data in support of its

methodology. An applicant for a Specialty ASTC should provide its own definitions of the surgeries and/or procedures that will be performed and whether the Surgical Cases will be performed in an Operating Room or a Procedure Room. An applicant for a Specialty ASTC must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON proposal to establish a Specialty ASTC or to expand existing services of a Specialty ASTC shall not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above. An applicant that is granted a CON for a Specialty ASTC shall have the specialty or limitation placed on the CON.

Not applicable to this project. The applicant is proposing a multi-specialty surgery center.

6. Access to ASTCs. The majority of the population in a Service Area should reside within 60 minutes average driving time to the facility.

   The majority of patients reside within 60 minutes of the facility.

   It appears this criterion has been met.

7. Access to ASTCs. An applicant should provide information regarding the relationship of an existing or proposed ASTC site to public transportation routes if that information is available

   The proposed site is not served by public transportation.

   It appears this criterion has been met.

8. Access to ASTCs. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project the origin of potential patients by percentage and county of residence and, if such data are readily available, by zip code, and must note where they are currently being served. Demographics of the Service Area should be included, including the anticipated provision of services to out-of-state patients, as well as the identity of other service providers both in and out of state and the source of out-of-state data. Applicants shall document all other provider alternatives available in the Service Area. All assumptions, including the specific methodology by which

utilization is projected, must be clearly stated.

The applicant projects 83% of patients will originate from the following areas: 6 Zip Codes in Rutherford County (71.4%), 3 Zip Codes in Davidson County (10.2%), 1 ZIP Code in Williamson County (1.5%), and 17% from other ZIP codes from other counties. The applicant provided a patient origin chart on page 38 of the application.

It appears this criterion has been met.

9. Access and Economic Efficiencies. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project patient utilization for each of the first eight quarters following completion of the project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

The applicant projected annual utilization and specific methodology on pages 53-54 of the original application.

It appears this criterion has been met.

10. Patient Safety and Quality of Care; Health Care Workforce.

a. An applicant should be or agree to become accredited by any accrediting organization approved by the Centers for Medicare and Medicaid Services, such as the Joint Commission, the Accreditation Association of Ambulatory Health Care (AAAHC), the American Association for Accreditation of Ambulatory Surgical Facilities, or other nationally recognized accrediting organization.

The applicant plans to seek accreditation by the Accreditation Association of Ambulatory Health Care (AAAHC).

It appears this criterion has been met.

b. An applicant should estimate the number of physicians by specialty that are expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel. An applicant should provide documentation on the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.

The applicant provided a table on page 40R of the original application listing the number of physicians by specialty expected to utilize the facility.

It appears this criterion has been met.

11 Access to ASTCs. In light of Rule 0720-11.01, which lists the factors concerning need on which an application may be evaluated, and Principle No. 2 in the State Health Plan, "Every citizen should have reasonable access to health care," the HSDA may decide to give special consideration to an applicant:

a. Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration;

The applicant documents partial areas of Davidson (Bordeaux/Inglewood Area), Rutherford (Christiana Area), and Williamson (Bethesda Area) Counties are medically underserved.

It appears this criterion has been met.

b. Who is a "safety net hospital" or a "children's hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program;

Since the applicant is not a hospital, this standard is not applicable to this proposed project.

c. Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program; or

- TennCare/Medicaid-Charges will equal $3,121,453 in Year One representing 12.0% of total gross revenue.
- Medicare/Managed Medicare- Charges will equal $6,633,088 representing 25.5% of total gross revenue.

It appears this criterion has been met.

d. Who is proposing to use the ASTC for patients that typically require longer preparation and scanning times. The applicant shall provide in its application information supporting the additional time required per Case and the impact on the need standard.

Not applicable. The applicant is not seeking special consideration for case times.

Staff Summary

The following information is a summary of the original application and all supplemental responses. Any staff comments or notes, if applicable, will be in bold italics.

Application Synopsis

StoneCrest Surgery Center, LLC seeks approval to establish and license a multi-specialty ambulatory surgical treatment center (ASTC). The ASTC will be located at an unaddressed site within the campus of StoneCrest Medical Center located at 200 StoneCrest Boulevard, Smyrna, (Rutherford County), TN 37167. The facility will contain 2 operating rooms and 1 procedure room.

The applicant seeks to provide a multi-specialty ASTC to patients who already utilize the StoneCrest Campus and surgical staff without having to commute away from their current preferred acute care campus. The applicant indicates the project will benefit patients and insurers with lower surgical costs by moving surgeries from StoneCrest Medical Center's inpatient and outpatient departments to the proposed multi-specialty ambulatory surgery center while still providing quality care. The proposed ASTC's primary service area will consist of 10 ZIP codes in Rutherford, Southeast Davidson, and East Williamson Counties that have contributed 83% of outpatient surgical cases at StoneCrest Medical Center in the past 18 months.

The applicant anticipates surgical cases will shift from the StoneCrest Medical Center's inpatient and outpatient surgery departments to the proposed ASTC. StoneCrest Medical Center's surgical utilization is projected to decrease by 1,629 cases, from 8,432 cases in 2019 to 6,803 in Year One (2020) of the proposed project. The applicant is projecting 1,950 total ASTC cases in Year One (2020) of the proposed project. Please see table on page 54 of the original application.

The proposed project is expected to open for service in October 2019.

Note to Agency members: If approved, the applicant is requesting 30 months, or 2 years 6 months to implement the proposed project. According to the applicant's Project Completion Forecast Chart, the final project report is projected to be submitted in March 2020.

Facility Information

- The total square footage of the proposed ASTC is 13,000 square feet. A floor plan drawing is included in Attachment A-6B (2)—Floor Plan.
- The proposed ASTC will contain two operating rooms, one procedure room, four pre-operative areas, six recovery areas, one sterile work and supply room, nurse's station, and waiting area.

Ownership

- StoneCrest Surgery Center is 100 percent owned by Surgicare of StoneCrest, LLC, whose ultimate parent organization is (through several corporate entities) HCA Healthcare, Inc. of Nashville, Tennessee.
- StoneCrest Surgery Center is part of the locally managed HCA, Inc. which operates several hospitals, surgery and imaging centers in Tennessee. An organizational chart and list of facilities in Tennessee is enclosed in Attachment A.4A.
- If approved, the applicant will offer minority membership (up to 49%) to StoneCrest Surgery Center's medical staff in a future syndication.

NEED

Project Need

The applicant states a certificate of need to establish a multi-specialty ASTC is being requested for the following reasons:

- Rutherford County has the fastest growing population of any county in Tennessee, according to current four year projections by the Tennessee Department of Health.
- The existing ambulatory surgical centers in the applicant's primary service area already meets the state health plan criterion for adding operating room capacity.
- The 3 multi-specialty ASTCs in the proposed service area had a 19.2% increase in OR cases from 2011 to 2016. This exceeded the overall increase of 12.2% for all area surgery centers.
- If approved, the proposed project will be helpful in recruiting new surgeons to the north Rutherford County community.

Service Area Demographics

StoneCrest Surgery Center's primary service area (PSA) consists of Davidson, Rutherford, and Williamson Counties. The applicant's proposed service area is based on 2016-2017 ZIP code data, 83% of outpatient surgical cases performed at StoneCrest Medical Center resided in 10 contiguous ZIP codes in Davidson, Rutherford, and Williamson Counties.

Highlights of the applicant's proposed 3 county 10 ZIP code service area are provided as follows:

- The total population of the PSA is estimated at 500,831 residents in CY 2017 increasing by approximately 6.9% to 535,619 residents in CY 2021.
- The overall Tennessee statewide population is projected to grow by 4.2% from 2017 to 2021.
- Residents age 65 and older account for approximately 11.2% of the total PSA population compared to 18.3% statewide.
- The age 65 and older resident population is expected to increase by 27.2% compared to 15.8% statewide from CY2017 - CY2021.
- The number of residents enrolled in TennCare is approximately 16.2% of the total PSA population compared to 20.5% statewide.

Service Area Historical Utilization

According to the Department of Health, in 2016 there were two licensed single-specialty ASTCs and four multi-specialty ASTCs in the proposed service area that consists of ten ZIP codes in Rutherford, southeast Davidson, and East Williamson County that perform similar cases of the specialties projected by the applicant.

County	Single Specialty ASTC	2014				2015				2016			
		# ORs	OR Cases	# PRs	Cases	# ORs	OR Cases	# PRs	# PR Cases	# ORs	# OR Cases	# PRs	# PR Cases
Rutherford	Mid-State Endoscopy Center	0	0	2	3,209	0	0	2	2,160	0	0	1	2,395
Rutherford	Williams Surgery Center (Podiatry)	1	67	0	0	1	56	0	0	1	44	0	0
Service Area	**Single-Specialty Subtotal**	**1**	**67**	**2**	**3,209**	**1**	**56**	**2**	**2,160**	**1**	**44**	**1**	**2,395**
	Multi-Specialty ASTCs												
Davidson	Premier Orthopedic Surgery Center	**2**	2,543	0	0	2	2,165	0	0	2	2,029	0	0
Rutherford	Middle TN Ambulatory Surg. Ctr.	**6**	5,609	1	666	6	5,837	1	873	6	6,214	1	934
Rutherford	Surgicenter of Murfreesboro Med. Clinic	**3**	3,729	3	5,138	3	4,034	3	5,426	3	4,237	3	6,036
Rutherford	Physicians Pavilion Surgery Ctr.	**4**	2,272	1	551	4	1,991	1	568	4	2,183	1	694
Service Area	**Multi-Specialty ASTCs Subtotal**	**15**	14,153	5	6,355	15	14,027	5	6,867	15	14,663	5	7,664
	Grand Total/Average	**16**	**14,220**	**7**	**9,564**	**16**	**14,083**	**7**	**9,027**	16	**14,707**	**6**	**10,059**

Source: Tennessee Department of Health, Division of Health Statistics, Joint Annual Reports

The above 3 county 10 ZIP code service area ASTC utilization table reflects the following:

- The proposed service area experienced a 25.4% decrease in Single Specialty ASTC procedure room cases from 3,209 in 2014 to 2,395 in 2016.
- The proposed service area experienced a 20.6% increase in Multi-Specialty Specialty ASTC PR surgical cases from 6,355 cases in 2014 to 7,664 cases in 2016.
- The proposed service area experienced a 3.4% increase in Multi-Specialty Specialty ASTC OR surgical cases from 14,153 cases in 2014 to 14,663 cases in 2016.

Applicant's Projected Utilization

The following are StoneCrest Surgery Center's surgical case projections by specialty for Year One and Year Two.

Specialty	Year 1 # of Surgeons	Year 1 Cases (2020)	Year 2 Cases (2021)
ENT	2	199	205
General Surgery	4	353	364
Gastroenterology	2	500	515
Gynecology	5	233	240
Orthopedic	5	304	313
Podiatry	3	112	115
Urology	3	237	244
Plastic Surgery	1	12	12
Total	**25**	**1,950**	**2,008**

Source: CN1707-23 Supplemental #1

- In Year One, Gastroenterology Surgery will represent 500 OR cases, or 26% of the total OR cases projected by StoneCrest Surgery Center.
- General Surgery will represent 353 OR cases, or 18.1% of the total OR cases projected by the applicant in Year One.
- All projections are based upon ASTC utilization by 25 surgeons.

The following is projected patient origin in Year 1 (2020) and 2 (2021) using StoneCrest Medical Center's historical utilization from 2015 to 2017.

Projected Patient Origin Stone Crest Surgery Center				
ZIP Code and Name	**Primary County**	**Projected % of total cases**	**Year 1 Cases**	**Year 2 Cases**
37167-Smyrna	Rutherford	33.1%	646	665
37086-LaVergne	Rutherford	16%	311	320
37129-Murfreesboro	Rutherford	9.2%	179	185
37013-Antioch	Davidson	7.4%	144	148
37128-Murfreesboro	Rutherford	6.8%	133	137
37130-Murfreesboro	Rutherford	4.5%	87	89
37127-Murfreesboro	Rutherford	1.8%	35	36
37211-Nashville	Davidson	1.6%	30	31
37135-Nolensville	Williamson	1.5%	29	30
37217-Nashville	Davidson	1.2%	24	25
Subtotal		83%	1,618	1,666
Other		17%	332	342
Grand Total			**1,950**	**2,008**

- Slightly over 33% of Projected Cases in Year One will originate from patients residing in the ZIP Code 37167 (Smryna).
- Three ZIP codes in Davidson County will represent 10.2% of total cases in Year One.
- The ZIP code 37135 (Williamson County) will represent 29 cases, or 1.5% of the total cases projected in Year One.

ECONOMIC FEASIBILITY

Project Cost

Major costs of the $10,556,553 total estimated project cost are as follows:

- Construction Cost (Lessee's buildout of shell)-$3,256,500 or approximately 30.8% of the total project cost.
- Building (lessor's cost to construct shell)-$2,925,000 or approximately 27.7% of total cost.
- Fixed Equipment-$2,750,000 or 26% of total cost.
- For other details on Project Cost, see the Project Cost Chart on page 56R of the application.
- The construction cost of the proposed 13,000 SF ASTC will equal $475.88 PSF.

Financing

A July 23, 2017 letter from C. Eric Lawson, TriStar Health's Chief Financial Officer, confirms TriStar Health has sufficient financial resources to fund StoneCrest Surgery Center's proposed project cost through a cash transfer.

HCA Holdings Inc.'s audited financial statements for the period ending December 31, 2015 indicates $741,000,000 in cash and cash equivalents, total current assets of $9,232,000,000, total current liabilities of $5,516,000,000, and a current ratio of 1.67:1.

Note to Agency members: Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

Historical Data Chart

- Since the applicant is applying for the establishment of an ASTC, a historical data chart is not applicable.

Projected Data Chart
Project Only

The applicant projects $26,012,110 in total gross revenue on 1,950 surgical cases during the first year of operation and $27,324,259 on 2,008 surgical cases in Year Two (approximately $13,608 per case). The Projected Data Chart reflects the following:

- Free Cash Flow (Net Balance + Depreciation) for the applicant will equal $408,108 in Year One decreasing to $386,017 in Year Two.
- Net operating revenue after bad debt and contractual adjustments is expected to reach $3,759,373 or approximately 13.8% of total gross revenue in Year Two.
- Charity Care will total $27,324 in Year Two which equals two surgical cases.

StoneCrest Medical Center Surgical Department

- Since the proposed surgery center will derive most of its surgical cases from StoneCrest Medical Center, a Projected Data Chart for StoneCrest Medical Center's Surgical Department (outpatient/inpatient) was provided.
- Free Cash Flow (Net Balance + Depreciation) for the applicant will equal $11,104,723 in Year One increasing to $11,619,142 in Year Two.

Charges

In Year One of the proposed project, the average charge per surgical case is as follows:

Average Gross Charge
- $13,340

Average Deduction from Operating Revenue
- $11,504

Average Net Charge
- $1,835

Payor Mix

- TennCare/Medicaid-Charges will equal $3,121,453 in Year One representing 12.0% of total gross revenue.
- Medicare/Managed Medicare-Charges will equal $6,633,088 representing 25.5% of total gross revenue.
- The applicant plans to contract with all TennCare Managed Care Organizations that serve the region.

PROVIDE HEALTHCARE THAT MEETS APPROPRIATE QUALITY STANDARDS

Licensure

- The applicant will seek licensure as an ambulatory surgery treatment center from the Department of Health.

Certification

- The applicant plans to apply for Medicare and Medicaid certification.

Accreditation

- The applicant will seek accreditation from the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE

Agreements

- The applicant will have an emergency transfer agreement with StoneCrest Medical Center (Rutherford County) which will be co-located with the applicant on the same medical campus.

Impact on Existing Providers

- Based upon existing services utilization, the proposed project should not impact multi-specialty ASTCs in the service area since the average

utilization already exceeds 70% which is the optimal threshold for adding OR capacity in an ASTC.

- TriStar StoneCrest Hospital will be the only provider significantly impacted since the proposed surgery center will derive most of its cases from StoneCrest Medical Center itself.

Staffing

The applicant's proposed direct patient care staffing in Year One includes the following:

Position Type	Year One FTEs
Registered Nurse OR	1.0
Registered Nurse PACU/Pre-op	3.00
Surgical Technicians	2.25
Materials Manager	1.0
OR Manager	1.0
Total	**8.25**

Source: CN1707-023

Corporate documentation, real estate lease, and detailed demographic information are on file at the Agency office and will be available at the Agency meeting.

Should the Agency vote to approve this project, the CON would expire in two years 6 months (30 months).

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT:

There are no other Letters of Intent, denied or pending applications, or Outstanding Certificates of Need for this applicant.

HCA has financial interests in this project and the following:

Denied Applications:

TriStar Southern Hills Medical Center Emergency Room, CN1412-050D, was denied at the March 25, 2015 Agency meeting. The application was for the establishment of a satellite emergency department facility in a leased building to be constructed. The facility was to contain 8 treatment rooms for emergency services at an unaddressed site at the intersection of Old Hickory Boulevard and American Way, Brentwood (Davidson County), TN 37250. The estimated project

cost was **$11,500,000.00.** *Reason for Denial: The application was denied based on inadequate proof of orderly development. This application is currently under appeal.*

Summit Medical Center, CN1206-029D, was denied at the September 26, 2012 Agency meeting. The application was for the establishment of a 20 bed acute inpatient rehab unit and service in its hospital facility by converting 20 adult psychiatric beds and reclassifying the adult psychiatric unit to an inpatient rehabilitation unit. The estimated project cost was **$2,500,000.00** *Reason for Denial: The need and orderly development aspects of the application failed to meet the statutory criteria.*

Outstanding Certificates of Need

TriStar Skyline Medical Center, CN1612-041A, has an outstanding Certificate of Need that will expire on June 1, 2020. The project was approved at the April 26, 2017 Agency meeting for the transfer of 31 medical-surgical beds from TriStar Skyline's satellite campus located at 500 Hospital Drive, Madison (Davidson County), TN, into newly constructed space at its main campus at 3441 Dickerson Pike, Nashville (Davidson County). The estimated project cost is **$30,038,000. Project Status Update:** *An update received July 31, 2017 indicates architectural planning is underway and construction has not yet started.*

Parkridge West Hospital, CN1611-039A, has an outstanding Certificate of Need that will expire on April 1, 2020. The project was approved at the February 22, 2017 Agency meeting for the conversion of 8 unstaffed medical surgical beds to adult (Age 18+) acute psychiatric beds. The applicant's adult psychiatric unit will increase from 20 beds to 28 beds. The overall licensed bed complement of the hospital, 70 beds, will not change. The estimated project cost is **$2,184,808.** *Project Status Update: An October 5, 2017 update from a project representative indicates the project is continuing to move forward and will be completed on or before the expiration date.*

TriStar Maury Regional Behavioral Healthcare, CN1610-036A, has an outstanding Certificate of Need that will expire on April 1, 2020. The project was approved at the February 22, 2017 Agency meeting for the establishment of a 60 bed mental health hospital for adolescents and adult patients located on the east side of North Campbell Boulevard, in the southeast quadrant of its intersection with Old Williamsport Pike, Columbia (Maury County), Tennessee 38401. The bed distribution will be 42 adult psychiatric beds and 18 adolescent psychiatric beds. The estimated project cost is **$24,033,031.** *Project Status Update: An October 6, 2017 update from a project representative indicates the following are projected to be completed in the 4th quarter of 2017: 1) Site land development, 2) Architectural drawing bid, and 3) the Joint Venture.*

Centennial Medical Center, CN1407-032A, has an outstanding Certificate of Need that will expire on June 29, 2019. The project was approved at the October 22, 2014 Agency meeting for the renovation of the main emergency department, the development of a Joint Replacement Center of Excellence with 10 additional operating rooms; and the increase of the hospital's licensed bed complement from 657 to 686 beds. The estimated project cost was **$96,192,007.00.** *Project Status An annual project report dated September 15, 2017 indicated the project was progressing with the vertical expansion on the North tower being complete, rough-ins were underway, and concrete slabs were planned to be poured in September 2017. The project is on schedule.*

TriStar Horizon Medical Center, CN1510-047A, has an outstanding Certificate of Need that will expire on March 1, 2019. The application was approved at the January 26, 2016 Agency meeting for the initiation of neonatal intensive care (NICU) services in a 6-bed Level II neonatal nursery through renovation of existing space on the 2nd floor of Horizon Medical Center located at 111 Highway 70 East in Dickson, Tennessee. The estimated project cost **is $975,500**. *Project Status Update: An October 6, 2017 update from a project representative indicated the project is near completion and is scheduled to be completed by November 1, 2017.*

Summit Medical Center, CN1508-031A, has an outstanding Certificate of Need that will expire on January 1, 2019. The project was approved at the November 18, 2015 Agency meeting for the establishment of a 8,864 SF satellite emergency department (ED) containing 8 examination and treatment rooms to be located at an unaddressed site in the southwest quadrant of intersection of I-40 and Beckwith Road (Exit 229), 100 yards west of Beckwith Road, Mt. Juliet (Wilson County), TN 37122. Located at interstate 40 Exit 229 approximately 9.9 miles east of TriStar Summit Medical Center's main emergency department, the proposed satellite ED will be a full-service, 24-hour, physician-staffed satellite facility operated as a department of Summit Medical Center with the same emergency medical physician coverage and full-time emergency diagnostic and treatment services as the main hospital. The estimated project cost is **$11,106,634**. *Project Status Update: According to an update received July 31, 2017, site plans are being finalized that include working with the city planning team to develop plans for utilities, roadway, lighting, etc. for approval by the City of Mt. Juliet.*

Parkridge Medical Center, CN1503-007A, has an outstanding Certificate of Need that will expire on July 1, 2018. The project was approved at the June 24, 2015 Agency meeting for the renovation and expansion of several patient care and support department areas of the facility and the acquisition of an additional cardiac catheterization laboratory and bone densitometry unit on its main campus. The project will not change the 275 licensed bed complement of the hospital. The estimated project cost is **$61,459,477**. *Project Status Update:*

According to an annual progress report submitted on 07/19/2017, the construction and renovation is underway in two phases. The first phase is anticipated to be completed by September 2017. Full completion is anticipated to be achieved by January 2018.

Southern Hills Surgery Center, CN1411-047A, has an outstanding Certificate of Need that will expire June 24, 2019. The project was approved at the May 27, 2015 Agency meeting for the relocation of Southern Hills Surgery Center from 360 Wallace Road, Nashville (Davidson County), TN 37211, to leased space in a building to be constructed at an unaddressed site in the northeast corner of the intersection of Old Hickory Boulevard and American Way, Brentwood (Davidson County), TN 37250. The estimated project cost is **$17,357,832.00.** *Project Status Update: An update received July 31, 2017 indicates since the favorable appeal decision on June 2, 2017, land has been purchased and space planning is underway. Construction has not yet begun.*

Hendersonville Medical Center, CN1302-002A, has an outstanding Certificate of Need that will expire on January 1, 2018. The project was approved at the June 26, 2013 Agency meeting to construct a new fourth floor of medical surgical beds and initiate Level IIB Neonatal Intensive Care services in a new six (6) bed licensed Level IIB Neonatal Intensive Care Unit (NICU) on its campus at 355 New Shackle Island Road, Hendersonville (Sumner County) Tennessee, 37075. The proposed project will not change the total licensed bed complement. The hospital currently holds a single consolidated license for 148 general hospital beds, of which 110 are located at its main Hendersonville campus and 38 are located at its satellite campus at 105 Redbud Drive, Portland (Sumner County), TN 37148. The applicant will relocate 13 beds from the satellite campus to the main campus, resulting in 123 licensed beds at the Hendersonville campus and 25 licensed beds at the Portland satellite campus. The estimated cost of the project is **$32,255,000.00.** *Project Status Update: According to an annual progress report submitted on 05/03/2017, the project is entering the final phase of the project with full completion of the project by November 2017.*

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

There are no other Letters of Intent, denied applications, or Outstanding Certificates of Need by other service area providers for similar services.

Pending Projects

Saint Thomas Surgery Center New Salem, LLC, CN1707-022, has a pending project that will be heard at the October 25, 2017 Agency meeting for the establishment of a multi-specialty ambulatory surgical treatment center (ASTC) with two operating rooms and one procedure room located at 2779 New Salem Road, Murfreesboro, (Rutherford County), TN 37128. The proposed project involves construction of 14,500 square feet (rentable) of new ASTC space. The applicant is owned by USP Tennessee, Inc. (50.1%) and St. Thomas Health (49.9%). The proposed service area includes a primary service area consisting of Rutherford County and a secondary service area consisting of Bedford, Cannon, Coffee, and Warren Counties. **The estimated project cost is $16,228,645.**

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, HEALTH CARE THAT MEETS APPROPRIATE QUALITY STANDARDS, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

PME (10/19/17)

LETTER OF INTENT

LETTER OF INTENT -- HEALTH SERVICES & DEVELOPMENT AGENCY

The Publication of Intent is to be published in the Tennessean, which is a newspaper of general circulation in Rutherford County, Tennessee, on or before July 20, 2017, for one day.

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that StoneCrest Surgery Center (a proposed ambulatory surgical treatment center), to be owned by StoneCrest Surgery Center, LLC (a limited liability company), and to be managed by Medical Care America, LLC, intends to file an application for a Certificate of Need to establish a multispecialty ambulatory surgical treatment center with two operating rooms and one procedure room, at an unaddressed site within the campus of StoneCrest Medical Center, a hospital whose address is 200 StoneCrest Boulevard, Smyrna, TN 37167. The project will be located on land at the intersection of StoneCrest Boulevard and Stonecrest Parkway, east of existing hospital campus buildings.

The project cost is estimated at $11,000,000, including the value of the land and building that will be leased to the applicant. The facility will seek licensure as an Ambulatory Surgical Treatment Center, from the Board for Licensing Health Care Facilities. The project will not contain major medical equipment and will not affect any licensed bed complements.

The anticipated date of filing the application is on or before July 25, 2017. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

John R Wellborn 7-19-17 jwdsg@comcast.net

(Signature) (Date) (E-mail Address)

Application
(COPY)

StoneCrest Surgery Center

CN1707-023

DSG Development Support Group

July 24, 2017

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application Submittal
StoneCrest Surgery Center
Smyrna, Rutherford County

Dear Mrs. Hill:

This letter transmits an original and two copies of the subject application. The affidavit and filing fee are enclosed.

As indicated to you in Jerry Taylor's letter of July 20, this application seeks simultaneous review with the application CN1707-022, for the Saint Thomas Surgery Center New Salem, LLC.

I am the contact person for this project. Jerry Taylor is legal counsel. Please advise me of any additional information you may need. We look forward to working with the Agency on this project.

Respectfully,

John Wellborn

John Wellborn
Consultant

4219 Hillsboro Road, Suite 203
Nashville, TN 37215
jwdsg@comcast.net
Tel 615.665.2022
Fax 615.665.2042

STONECREST SURGERY CENTER

CERTIFICATE OF NEED APPLICATION FOR A LICENSED MULTISPECIALTY AMBULATORY SURGICAL TREATMENT CENTER ON THE CAMPUS OF TRISTAR STONECREST MEDICAL CENTER

SMYRNA, TENNESSEE

Filed July 2017

CERTIFICATE OF NEED APPLICATION

SECTION A: APPLICANT PROFILE

1. Name of Facility, Agency, or Institution

StoneCrest Surgery Center		
Name		
Unaddressed site at intersection of StoneCrest Boulevard and Stonecrest Parkway within the campus of StoneCrest Medical Center (200 StoneCrest Blvd)		Rutherford
Street or Route		*County*
Smyrna	TN	37167
City	*State*	*Zip Code*
tristarstonecrest.com		
Website Address		

2. Contact Person Available for Responses to Questions

John Wellborn			Consultant
Name			*Title*
Development Support Group			jwdsg@comcast.net
Company Name			*E-Mail Address*
4219 Hillsboro Road, Suite 210	Nashville	TN	37215
Street or Route	*City*	*State*	*Zip Code*
CON Consultant	615-665-2022		615-665-2042
Association With Owner	*Phone Number*		*Fax Number*

NOTE: **Section A** is intended to give the applicant an opportunity to describe the project. **Section B** addresses how the project relates to the criteria for a Certificate of Need by addressing: Need, Economic Feasibility, Contribution to the Orderly Development of Health Care, and Quality Measures. Please answer all questions on 8.5" X 11" white paper, clearly typed and spaced, single-sided, in order and sequentially numbered. In answering, please type the question and the response. All questions must be answered. If an item does not apply, please indicate "N/A" (not applicable). Attach appropriate documentation as an Appendix at the end of the application and reference the applicable Item Number on the attachment, i.e., Attachment A.1, A.2, etc. The last page of the application should be a completed and signed notarized affidavit.

3. SECTION A: EXECUTIVE SUMMARY

A. Overview

Please provide an overview not to exceed three pages in total, explaining each numbered point.

(1) Description (Address the establishment of a health care institution, initiation of health services, bed complement changes, and/or how this project relates to any other outstanding but unimplemented certificates of need held by the applicant.)

- The application is to establish a new multi-specialty Ambulatory Surgical Treatment Center on the campus of TriStar StoneCrest Medical Center, in Smyrna in north Rutherford County, at an estimated cost of approximately $10,556,553, including market values of leased space and land.

- The TriStar StoneCrest campus has served the rapidly growing sectors of Rutherford, southeast Davidson, and east Williamson County for fourteen years, since its opening in 2003. It is one of only two hospitals in its county, which is the fastest growing county in Tennessee. StoneCrest is a fully accredited, 109-bed general acute care facility with a comprehensive range of services including neonatal intensive care, radiation therapy, and other highly specialized services.

- As a joint venture between the hospital and its surgical staff, this facility will provide StoneCrest's current patients and surgeons with improved patient care options and new opportunities to partner with hospitals on surgical care processes, without commuting away from their current preferred acute care campus. It is focused on providing benefits for patients who already utilize the StoneCrest campus and surgical staff.

- The facility will have two (2) operating rooms and one (1) procedure room, in approximately 13,000 SF of space. I will have 3 pre-op and 4 post-op recovery stations, with all required support spaces. The facility is projected to perform cases primarily in these eight medical specialties during its first two years. Additional specialties may be added at a later time.

Gastroenterology	Gynecology	Otolaryngology (ENT)	Podiatry
General Surgery	Orthopedics	Plastic Surgery	Urology

(2) Ownership Structure

- Like its sponsoring hospital, this will be an HCA-affiliated facility.

- The CON applicant is StoneCrest Surgery Center, LLC. It is wholly owned by Surgicare of StoneCrest, LLC, which is wholly owned by Medical Care America, LLC, which is wholly owned by HealthTrust, Inc.-The Hospital Company, which is wholly owned by HCA, Inc.,which is wholly owned by HCA Healthcare, Inc., which is a publicly traded company.

- The facility's license will be held by StoneCrest Surgery Center, LLC, a new limited liability company. Currently all of that LLC's membership interests are owned by Surgicare of StoneCrest, LLC, which will offer minority membership interests to the surgery center's medical staff in a future syndication.

(3) Service area

• The facility's primary service area, from which 83% of its cases will originate, will consist of ten zip codes in Rutherford, southeast Davidson, and east Williamson County. These are the zip codes that have contributed 83% of outpatient surgical cases performed at StoneCrest Medical Center in the past 18 months, in the eight surgical specialties identified above. The zip codes are:

37086 Lavergne--Rutherford County	37167 Smyrna--Rutherford County
37127 Murfreesboro--Rutherford County	37013 Antioch--Davidson County
37128 Murfreesboro--Rutherford County	37211 Nashville--Davidson County
37129 Murfreesboro--Rutherford County	37217 Nashville--Davidson County
37130 Murfreesboro--Rutherford County	37135 Nolensville-Williamson County

(4) Existing similar service providers

• The similar or comparable service providers that will be in operation in the primary service area when this facility opens will consist of six multispecialty and single-specialty surgery centers, that perform cases of the specialties projected in this application:

Middle Tennessee Ambulatory Surgery Center	Multispecialty	Murfreesboro
Surgicenter of Murfreesboro Medical Clinic	Multispecialty	Murfreesboro
Williams Surgery Center	Podiatry	Murfreesboro
Mid-State Endoscopy Center	Gastroenterology	Murfreesboro
Physicians Pavilion Surgery Center	Multispecialty	Smyrna
Premier Orthopedic Surgery Center	Orthopedic	Nashville

This group of six facilities excludes some surgery centers that do procedures of types other than what will be offered in this proposed surgery center. For example, eye surgery and pain management.

• These facilities are well-utilized. Their 2016 Joint Annual Reports document that as a group, their 16 operating rooms were utilized at 72.8%. Excluding the private practice podiatry facility--which at only 44 annual cases was not a significant surgical resource for area residents-- the utilization of these primary service area operating rooms was 77.4%. These group occupancies exceeded the criterion of the State Health Plan recommending that comparable facilities in the applicant's service area should be at least 70% utilized for additional operating rooms to be approved.

(5) Project cost

• The projected project cost for CON purposes is estimated at $10,556,553. However, this includes approximately $4 million of market value of the land and building being leased from an HCA affiliate by the applicant in order to build out and establish the surgery center. The project's actual capital costs are estimated to be approximately $9,685,553. Its cost of construction is estimated at approximately $476 PSF for both the shell building and its build-out.

(6) Funding

• The project will be fully funded by an affiliate of HCA Healthcare, Inc., the ultimate parent of TriStar StoneCrest Medical Center, and by a syndication offered to StoneCrest surgeons. The funding will be provided through cash transfers to Medical Care America, LLC, also an affiliate of HCA Healthcare, Inc.

• Excluding the value of the project site, which is already owned by an HCA affiliate, the actual cost required for the project is estimated at $9,685,353. Of this, the parent companies will provide $8,029,067--assuming the syndicated physicians provide $1,656,286. The parent companies will provide any additional funding required in the event of a shortfall of the syndication target.

(7) Financial feasibility, including when the proposal will realize a positive financial margin; and

• As shown in the Projected Data Chart for the facility and for StoneCrest Medical Center's surgery department, in Years One and Two of the surgery center's operation both the surgery center and the hospital's surgery department will have positive cash flows and positive operating margins.

(8) Staffing

• The StoneCrest Surgery Center will require an estimated 11.25 FTE's in its first year of operation. Of these, 8.25 FTE's will be clinical personnel (primarily nurses) and 3 FTE's will be non-clinical personnel (administrator, business office manager, receptionist, and other clerical.)

B. Rationale for Approval

A certificate of need can only be granted when a project is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of adequate and effective health care in the service area. This section should provide rationale for each criterion using the data and information points provided in Section B of this application. Please summarize, in one page or less, each of the criteria.

(1) Need

This project has been designed to meet the needs and expectations of patients and physicians who are choosing to utilize TriStar StoneCrest's north Rutherford County campus for acute care. The need for the project is driven and supported by four main factors:

Factor 1: Existing ambulatory surgical centers in StoneCrest's Primary Service Area Already Meet the State Health Plan Criterion for Adding Operating Room Capacity to the Service Area.

The surging populations in and near Rutherford County have filled the project service area's comparable surgery center's average O.R. utilization to beyond the 70% "optimal" threshold that the State Health Plan recommends for approval of additional capacity.

The most current available data from the eight "comparable" existing facilities, for CY 2016, demonstrates the following:

- The project's primary service area is defined by 1.5 years of surgical outpatient origin at StoneCrest Medical Center for the medical specialties to be offered in this facility. The primary service area is designated as ten zip codes covering parts of Rutherford, southeast Davidson, and east Williamson Counties.

- In that primary service area, there will be six ASTC's that provide services in the eight specialties projected for the StoneCrest Surgery Center. (A seventh ASTC has been inactive until several months ago and it has been granted CON approval to move outside this project's primary service area into zip code 37207.

- Only three of these six surgery centers are multi-specialty facilities like StoneCrest's proposed project. One of the other three is a private-practice podiatry facility that only performed 44 cases last year and cannot reasonably be considered a community resource comparable to the other centers. There is also an endoscopy center and an orthopedic center.

- 94% of the O.R.'s in this service area are in the five facilities other than the podiatry center. Their average O.R. utilization exceeded 77% last year. The three multispecialty centers alone averaged 77%. Even the entire six-facility group average was almost 73%. No matter how grouped, last year the existing ASTC's in the defined project service area significantly exceeded the State Health Plan's criterion of 70% areawide O.R. utilization, at which additional O.R. capacity may be approved.

Factor 2. Surgery Center utilization in Rutherford County Will Continue to Increase.

• Multispecialty facilities are the most appropriate type of surgery center to consider in projecting future area needs. Single-specialty facilities are often private practice facilities with very limited medical staff and a narrow scope of service. The service area's need is better indicated by facilities with larger service scope and medical staff depth.

• The three multispecialty facilities in the project service area are all in fast-growing Rutherford County. Joint Annual Report Data for 2011-2016 indicates that they had a 19.2% increase in O.R. cases in the five years from 2011 to 2016. This far exceeded the overall increase of 12.2% for all area surgery centers.

• If the same historic 5-year O.R. case growth rate is projected to 2021 (the second year of operation for StoneCrest Surgery Center) it indicates that these three facilities can share approximately 15,060 O.R. cases. They have 13 O.R.s. That would give them a group average of 1,158 O.R. cases per O.R.--131% above the 884 cases that the State Health Plan defines as optimal 70% utilization of an O.R. StoneCrest Surgery Center, with a different staff of surgeons, will obtain most of its O.R. cases from different referral patterns, and from recruitment of new surgeons.

• There are additional indicators of strong growth in demand for surgery center O.R. capacity in this market, emanating from the Federal level. CMS (Medicare) is currently proposing to add three surgical procedures to the ASC covered procedures list (CPL). (i.e., to reimburse them if done in a surgery center). More significantly, CMS is soliciting public comment on whether several joint replacement surgeries--total knee arthroplasty, partial hip arthroplasty, and total hip arthroplasty--meet the criteria to be added to the ASC-CPL. These are high-volume cases that currently are reimbursed only in a hospital setting. If approved for surgery centers, as many anticipate, the need of patients, employers, and insurors (including Medicare) to reduce their costs of care will drive new demand for surgery center O.R. time.

• Published materials in the application's first attachment provide a government and industry-wide perspective on the extraordinarily large savings that are accruing to both patients and insurors (including Medicare) as inpatient or hospital outpatient department (HOPD) surgeries are moved to ambulatory surgery centers. This is causing hospital organizations across the country to establish their own affiliated, quality-controlled surgery centers for their own patients. The StoneCrest Surgery Center project is a necessity for service area patients and their payors.

Factor 3: Rapid population growth in this area will require acute care providers to offer more ambulatory surgery capacity in this decade.

• The StoneCrest acute care campus is in Rutherford County. More than 74% of StoneCrest's outpatient surgery patients are residents of Rutherford County. Rutherford County has the fastest-growing population of any county in Tennessee, according to current four-year projections by the Tennessee Department of Health. The county's growth rate is the State's only double-digit rate. The county is projected to increase in population by 11.9% between now and CY 2021. This is 280% of the projected Statewide population growth (4.2%) in that time period.

Moreover, Rutherford County is experiencing that growth on a population base that is already very large. It is Tennessee's fifth most populous county, having already more than 150% of the population of adjoining Williamson County. Rutherford County's population is projected to be almost equal to that of Chattanooga/Hamilton County in four more years.

• Rapid growth is not confined to the Rutherford County portion of StoneCrest's primary service area. This project's primary service area ("PSA") consists of ten zip codes in Rutherford County and nearby parts of Southeast Davidson County and eastern Williamson County that generate approximately 83% of StoneCrest's outpatient surgery cases in the eight main specialties that will use this surgery center. Those zip codes are increasing significantly in population. Commercial population projections indicate that over the next four years, their adult population will increase by 7.5%, much faster than the Department of Health's forecast rate of 4.2% Statewide. Commercial sources project that these zip codes' elderly population will increase by 27.1% in the next four years. By contrast, the Department of Health projects that the Statewide elderly population will increase by only 15.8% during that period.

This growth will continue to fuel demand for steadily increasing acute care service capacity. Recruitment of additional physicians will be necessary to meet these demands. This project will be particularly helpful to StoneCrest Medical Center in recruiting new surgeons to the north Rutherford County community.

Factor 4: The Project Meets an Area Need for Continued Diversification in Patient Care Options.

Patients and their physicians have evolving and reasonable expectations of acute care providers:

- They are asking for simpler and more efficient processes and paperwork in acute care settings.
- They need to lower their costs of care.
- Surgeons want a stronger voice in operation of their surgical suites.
- Many patients would like to avoid the risks of entering hospital buildings where new drug-resistant infections are becoming more of an issue than in past years.

The public and the medical staff need these reasonable options. Being able to use a hospital-affiliated, quality-controlled freestanding ambulatory surgery center addresses all of those concerns and preferences. It is increasingly attractive to patients and to their surgeons.

HCA affiliates operate four general acute care hospitals in Davidson County, and three of them have already acquired or established hospital-affiliated, physician joint-ventured ambulatory surgery centers to provide their patients and medical staff with this attractive option.

In Rutherford County, the only acute care hospital other than StoneCrest has already received CON approval for two affiliated surgery centers and is proposing a third one.

This project affirms TriStar StoneCrest's commitment to move in a similar direction. Having attempted unsuccessfully for some time now to acquire an existing surgery center in its primary service area, the hospital is now requesting approval to construct an ambulatory surgery center on its own campus, to provide this important option for its patients, physicians, and community.

(2) Economic Feasibility

As shown in the Projected Data Chart for the facility and for StoneCrest Medical Center's surgery department, both the facility and the hospital's surgery department will have positive cash flows and positive operating margins during Years One and Two of the surgery center's operation.

Hospital projections that indicate a feasible operational performance are conservative. The cases projected for Years One and Two of the proposed surgery center and for the hospital's Surgery Department are cases already being performed on the campus--increased annually by small percentages that are lower than the compound annual growth rate for the hospital's outpatient surgeries for the past two and a half years. The project's feasibility will not depend on increasing StoneCrest's market share of surgical outpatients or taking cases from other providers.

	Actual 2015	Actual 2016	Ann'd 2017	Proj 2018	Proj 2019	Proj Yr 1 2020	Proj Yr 2 2021
Total Campus Cases	6,677	6,970	7,826	8,123	8,432	8,753	9,084
Annual Increase	7.7%	4.4%	12.3%	3.8%	3.8%	3.8%	3.8%
2015-2017 CAGR			>8%				
Total Campus OP Cases	5,455	5,601	6,238	6,488	6,748	7,018	7,298
Annual Increase	10.9%	2.7%	11.4%	4.0%	4.0%	4.0%	4.0%
2015-2017 CAGR			c. 7%				
Surgery Center Cases						1,950	2,008
Annual Increase						--	3.0%

The ability of the applicant to secure funding for the project through TriStar Health System is clearly documented by the financial statements of the parent company contained in the Attachments to the application.

(3) Appropriate Quality Standards

The facility will seek accreditation from the Accreditation Association for Ambulatory Health Care. Its two principal owners will be HCA subsidiaries with long established records of meeting and exceeding applicable quality standards of licensure and accreditation agencies. Medical Care America, an HCA subsidiary dedicated to ambulatory surgery center operations has 133 similar facilities across America; and all are AAAHC-accredited and licensed. All have the company's robust Quality Improvement and Risk Management Programs.

This facility will also reflect the high standards of StoneCrest Medical Center. The hospital has been named by the Joint Commission for 6 consecutive years as a Top Performer on Key Quality Measures, and has an "A" Patient Safety Score from the LeapFrog Group. Blue Cross/Blue Shield has named StoneCrest as a Blue Distinction Center for Knee and Hip Surgery as well as for Maternity Services. The hospital has also earned the American College of Surgeons' Center on Cancer Commission's Outstanding Achievement Award and a Best in Value Award from DataAdvantage.

(4) Orderly Development of adequate and effective health care

Hospital providers recognize that many surgical outpatients and surgeons in the community increasingly prefer to use an ambulatory surgery option that is not physically or operationally part of a hospital. A separately licensed ambulatory surgery center can offer faster and simpler processes and paperwork, lower costs, stronger relationships with the physician staff, and avoidance of medication-resistant infection risks within a hospital.

TriStar hospitals in Middle Tennessee have recognized this, and have gradually moved to acquire or to construct affiliated surgery centers near their hospitals. To date, affiliated surgery centers have been approved for, or acquired by, TriStar's Centennial Medical Center, Southern Hills Medical Center, Summit Medical Center, and Horizon Medical Center. TriStar's StoneCrest and Skyline hospitals have not yet created this option for their patients.

However, TriStar StoneCrest Medical Center has been attempting to accomplish it. StoneCrest has been discussing a joint-ventured surgery center option with its medical staff since 2014. Interest is now strong enough, and case growth is strong enough, to make such a project appropriate. Before proposing to develop additional operating room capacity in the primary service area, StoneCrest has pursued ASTC acquisition opportunities in its service area--but without success. The hospital's best remaining option is now requesting approval to construct an ambulatory surgery center on its own campus, to provide this important option for its patients, physicians, and community.

The timing of this project is appropriate. This is a high-growth service area. Continuous recruitment of physicians is necessary to keep up with increasing demand for adequate and effective health care. Recruitment of additional surgeons to the hospital will be enhanced by being able to offer a joint-ventured surgery center option.

The hospital-affiliated surgery center option has become an operational necessity for this provider in this service area. The service area's only other hospital has already established two (and is proposing a third) joint-ventured ambulatory surgical treatment centers in Rutherford County. Having attempted unsuccessfully for some time now to acquire an existing surgery center in its primary service area, the hospital is now requesting approval to construct an ambulatory surgery center on its own campus, to provide this important option for its patients, physicians, and community.

C. Consent Calendar Justification

If consent calendar is requested, please provide the rationale for an expedited review. A request for Consent Calendar must be in the form of a written communication to the Agency's Executive Director at the time the application is filed.

Review on the consent calendar is not requested.

SECTION A (CONTINUED): PROJECT DETAILS

4.A. Owner of the Facility, Agency, or Institution

StoneCrest Surgery Center, LLC (Att: Real Estate Dept)	615-344-2000
Name	*Phone Number*

One Park Plaza	Davidson
Street or Route	*County*

Nashville	TN	37203
City	*State*	*Zip Code*

B. Type of Ownership or Control (Check One)

A. Sole Proprietorship		F. Government (State of TN or Political Subdivision)	
B. Partnership		G. Joint Venture	
C. Limited Partnership		H. Limited Liability Company	*X*
D. Corporation (For-Profit)		I. Other (Specify):	
E. Corporation (Not-for-Profit)			

Attach a copy of the partnership agreement, or corporate charter and certificate of corporate existence. Please provide documentation of the active status of the entity from the TN Secretary of State's website hpps://tnbear.tn.gov/Ecommerce/FilingSearch.aspx.

See Attachment Section A-4A.

Describe the existing or proposed ownership structure of the applicant, including an ownership structure organizational chart. Explain the corporate structure and the manner in which all entities of the ownership structure relate to the applicant. As applicable, identify the members of the ownership entity and each member's percentage of ownership, for those members with 5% ownership (direct or indirect) interest.

An organization chart is included in Attachment Section A-4A.

5A. Name of Management/Operating Entity (If Applicable)

Medical Care America, LLC		
Name		
13355 Noel Road, Suite 650		Dallas
Street or Route		*County*
Dallas	TX	75240
City	*State*	*Zip Code*
https://hcahealthcare.com/about/hca-at-a-glance.dot		
Website Address		

For new facilities or existing facilities without a current management agreement, attach a copy of a draft management agreement that at least includes the anticipated scope of management services to be provided, the anticipated term of the agreement, and the anticipated management fee payment methodology and schedule. For facilities with existing management agreements, attach a copy of the fully executed final contract.

See Attachment Section A-5A.

6A. Legal Interest in the Site of the Institution (Check One)

A. Ownership		D. Option to Lease	
B. Option to Purchase		E. Other (Specify):	
C. Lease of 10 Years	X		

Check appropriate line above: For applicants or applicant's parent company/owner that currently own the building/land for the project location, attach a copy of the title/deed. For applicants or applicant's parent company/owner that currently lease the building/land for the project location, attach a copy of the fully executed lease agreement. For projects where the location of the project has not been secured, attach a fully executed document including Option to Purchase Agreement, Option to Lease Agreement, or other appropriate documentation. Option to Purchase Agreements must include anticipated purchase price. Lease/Option to Lease Agreements must include the actual/anticipated term of the agreement and actual/anticipated lease expense. The legal interests described herein must be valid on the date of the Agency's consideration of the certificate of need application.

See Attachment Section A-6A.

6B. Attach a copy of the site's plot plan, floor plan, and if applicable, public transportation route to and from the site, on an 8.5" X 11 sheet of white paper, single-sided. Do not submit blueprints. Simple line drawings should be submitted and need not be drawn to scale.

(1) Plot Plan must include:

a. Size of site (in acres);
b. Location of structure on the site;
c. Location of the proposed construction/renovation; and
d. Names of streets, roads, or highways that cross or border the site.

See Attachment Section A-6B-1.

(2) Attach a floor plan drawing for the facility, which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. On an 8.5" X 11" sheet of paper or as many as necessary to illustrate the floor plan.

See Attachment Section A-6B-2.

(3) Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.

See Attachment Section A-6B-3.

7. Type of Institution (Check as appropriate—more than 1 may apply)

A. Hospital (Specify):		H. Nursing Home	
B. Ambulatory Surgical Treatment Center (ASTC) Multi-Specialty	X	I. Outpatient Diagnostic Center	
C. ASTC, Single Specialty		J. Rehabilitation Facility	
D. Home Health Agency		K. Residential Hospice	
E. Hospice		L. Non-Residential Substitution-Based Treatment Center for Opiate Addiction	
F. Mental Health Hospital		M. Other (Specify):	
G. Intellectual Disability Institutional Habilitation Facility ICFF/IID			

8. Purpose of Review (Check as appropriate—more than 1 may apply)

A. New Institution	X	F. Change in Bed Complement *Please note the type of change by underlining the appropriate response: Increase, Decrease, Designation, Distribution, Conversion, Relocation*	
B. Modifying an ASTC with limitation still required per CON		G. Satellite Emergency Department	
C. Addition of MRI Unit		H. Change of Location	
D. Pediatric MRI		I. Other (Specify):	
E. Initiation of Health Care Service as defined in TCA Sec 68-11-1607(4) (Specify)			

9. Medicaid/TennCare, Medicare Participation

MCO Contracts (Check all that apply: Applicant will seek contracts with all area MCOs.
____Amerigroup ____United Healthcare Community Plan _____BlueCare _____TennCare Select
Medicare Provider Number: To be requested
Medicaid Provider Number: To be requested
Certification Type: Ambulatory Surgical Treatment Center
If a new facility, will certification be sought for Medicare or for Medicaid/TennCare?
Medicare Yes x No N/A
Medicaid/TennCare Yes x No N/A

10. Bed Complement Data

Not applicable.

A. Please indicate current and proposed distribution and certification of facility beds.)

	Beds Currently Licensed	Beds Staffed	Beds Proposed	*Beds Approved	**Beds Exempt	TOTAL Beds at Completion
1. Medical						
2. Surgical						
3. ICU/CCU						
4. Obstetrical						
5. NICU						
6. Pediatric						
7. Adult Psychiatric						
8. Geriatric Psychiatric						
9. Child/Adolescent Psychiatric						
10. Rehabilitation						
11. Adult Chemical Dependency						
12. Child/Adolescent Chemical Dependency						
13. Long-Term Care Hospital						
14. Swing Beds						
15. Nursing Home SNF (Medicare Only)						
16. Nursing Home NF (Medicaid Only)						
17. Nursing Home SNF/NF (dually certified MCare/Maid)						
18. Nursing Home-Licensed (Noncertified)						
19. ICF/IID						
20. Residential Hospice						
TOTAL						

** Beds approved but not yet in service* *** Beds exempted under 10%/3 yrs provision*

B. Describe the reasons for change in bed allocations and describe the impact the bed changes will have on the applicant facility's existing services.

Not applicable.

C. Please identify all the applicant's outstanding Certificate of Need projects that have a licensed bed change component. If applicable, complete the chart below.

CON Number	CON Expiration Date	Total Licensed Beds Approved
1. CN 1612-041 Skyline Medical Center		31-bed transfer between campuses No change in 385-bed license

11. Home Health Care Organizations – Home Health Agency, Hospice Agency (excluding Residential Hospice), identify the following by checking all that apply:

Not applicable.

	Existing Licensed County	Parent Office County	Proposed Licensed County		Existing Licensed County	Parent Office County	Proposed Licensed County
Anderson	☐	☐	☐	Lauderdale	☐	☐	☐
Bedford	☐	☐	☐	Lawrence	☐	☐	☐
Benton	☐	☐	☐	Lewis	☐	☐	☐
Bledsoe	☐	☐	☐	Lincoln	☐	☐	☐
Blount	☐	☐	☐	Loudon	☐	☐	☐
Bradley	☐	☐	☐	McMinn	☐	☐	☐
Campbell	☐	☐	☐	McNairy	☐	☐	☐
Cannon	☐	☐	☐	Macon	☐	☐	☐
Carroll	☐	☐	☐	Madison	☐	☐	☐
Carter	☐	☐	☐	Marion	☐	☐	☐
Cheatham	☐	☐	☐	Marshall	☐	☐	☐
Chester	☐	☐	☐	Maury	☐	☐	☐
Claiborne	☐	☐	☐	Meigs	☐	☐	☐
Clay	☐	☐	☐	Monroe	☐	☐	☐
Cocke	☐	☐	☐	Montgomery	☐	☐	☐
Coffee	☐	☐	☐	Moore	☐	☐	☐
Crockett	☐	☐	☐	Morgan	☐	☐	☐
Cumberland	☐	☐	☐	Obion	☐	☐	☐
Davidson	☐	☐	☐	Overton	☐	☐	☐
Decatur	☐	☐	☐	Perry	☐	☐	☐
DeKalb	☐	☐	☐	Pickett	☐	☐	☐
Dickson	☐	☐	☐	Polk	☐	☐	☐
Dyer	☐	☐	☐	Putnam	☐	☐	☐
Fayette	☐	☐	☐	Rhea	☐	☐	☐
Fentress	☐	☐	☐	Roane	☐	☐	☐
Franklin	☐	☐	☐	Robertson	☐	☐	☐
Gibson	☐	☐	☐	Rutherford	☐	☐	☐
Giles	☐	☐	☐	Scott	☐	☐	☐
Grainger	☐	☐	☐	Sequatchie	☐	☐	☐
Greene	☐	☐	☐	Sevier	☐	☐	☐
Grundy	☐	☐	☐	Shelby	☐	☐	☐
Hamblen	☐	☐	☐	Smith	☐	☐	☐
Hamilton	☐	☐	☐	Stewart	☐	☐	☐
Hancock	☐	☐	☐	Sullivan	☐	☐	☐
Hardeman	☐	☐	☐	Sumner	☐	☐	☐
Hardin	☐	☐	☐	Tipton	☐	☐	☐
Hawkins	☐	☐	☐	Trousdale	☐	☐	☐
Haywood	☐	☐	☐	Unicoi	☐	☐	☐
Henderson	☐	☐	☐	Union	☐	☐	☐
Henry	☐	☐	☐	Van Buren	☐	☐	☐
Hickman	☐	☐	☐	Warren	☐	☐	☐
Houston	☐	☐	☐	Washington	☐	☐	☐
Humphreys	☐	☐	☐	Wayne	☐	☐	☐
Jackson	☐	☐	☐	Weakley	☐	☐	☐
Jefferson	☐	☐	☐	White	☐	☐	☐
Johnson	☐	☐	☐	Williamson	☐	☐	☐
Knox	☐	☐	☐	Wilson	☐	☐	☐
Lake	☐	☐	☐				

12. Square Footage and Cost Per Square Footage Chart--Stonecrest Surgery Center

Unit/Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage		
					Renovated	New	Total
Ambulatory Surgery Center	NA	NA	NA	NA	0	13,000	13,000
							0
							0
							0
							0
							0
							0
							0
							0
							0
							0
							0
							0
							0
							0
							0
							0
							0
							0
							0
							0
Unit/Dept GSF Subtotal		0			0	13,000	13,000
Other GSF Subtotal					0	0	0
Total GSF		0			0	13,000	13,000
Total Cost*					$0.00	$6,186,500.00	$6,186,500.00
**Cost Per Square Foot							$475.88
Cost per Square Foot is Within Which Range?					___ Below 1st Quartile	___ Below 1st Quartile	___ Below 1st Quartile
					___ Between 1st and 2nd Quartile	___ Between 1st and 2nd Quartile	___ Between 1st and 2nd Quartile
(For quartile ranges, please refer to the Applicant's Toolbox on www.tn.gov/hsda)					___ Between 2nd and 3rd Quartile	___ Between 2nd and 3rd Quartile	___ Between 2nd and 3rd Quartile
					___ Above 3rd Quartile	___ Above 3rd Quartile	___ Above 3rd Quartile

Response: The HSDA Toolbox has no current or recent data on ASTC costs PSF by quartile.

** The Total Construction Cost should equal the Construction Cost reported on line A5 of the Project Cost Chart.*

*** Cost per Square Foot is the construction cost divided by the square feet. Please do not include contingency costs.*

ARCHITECT SHOULD ENTER COST PSF ONLY FOR NEW AND RENOVATED COLUMNS; THE TOTAL COST PSF COLUMN CALCULATES AUTOMATICALLY.

13. MRI, PET, and/or LINEAR ACCELERATOR

Describe the acquisition of any Magnetic Resonance Imaging (MRI) scanner that is adding an MRI scanner in counties with population less than 250,000, or is initiating pediatric MRI in counties with population greater than 250,000, and/or describe the acquisition of any Positron Emission Tomography (PET) unit or Linear Accelerator unit if initiating the service by responding to the following:

A. Complete the Chart below for acquired equipment.

Not applicable.

LINEAR ACCELERATOR	
Mev:	Total Cost*: $
Types: (indicate one)	By Purchase? __
__ SRS	By Lease? __
__ IMRT	
__ IGRT	Expected Useful Life (yrs): __
__ Other :	New? __
	Refurbished? __
	If not new, how old (Yrs)? __

MRI	
Tesla:	Total Cost*: $
Magnet: (indicate one)	By Purchase? __
__ Breast	By Lease? __
__ Extremity?	
__ Open?	Expected Useful Life (yrs): __
__ Short Bore?	New? __
__ Other -- _____	Refurbished? __
	If not new, how old (Yrs)? __

PET	
PET Only? __	Total Cost*: $
	By Purchase? __
PET/CT? __	By Lease? __
PET/MRI? __	Expected Useful Life (yrs): __
	New? __
	Refurbished? __
	If not new, how old (Yrs)? __

**As defined by Agency Rule 0720-9-.01(13)*

B. In the case of equipment purchase, include a quote and/or proposal from an equipment vendor. In the case of equipment lease, provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments along with the fair market value of the equipment.

Not applicable.

C. Compare the lease cost of the equipment to its fair market value. Note: Per Agency rule, the higher cost must be identified in the project cost chart.

Not applicable.

D. Schedule of Operations: Not applicable.

Location	Days of Operation (Sun-Sat)	Hours of Operation
Fixed Site (Applicant)		
Mobile Locations		
Applicant		
Name of other location		
Name of other location		
Name of other location		
Name of other location		
Name of other location		

E. Identify the clinical applications to be provided, that apply to the project.

Not applicable.

F. If the equipment has been approved by the FDA within the past five years, provide documentation of the same.

Not applicable.

SECTION B: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with T.C.A. § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, will provide health care that meets appropriate quality standards, and will contribute to the orderly development of health care." Further standards for guidance are provided in the State Health Plan developed pursuant to T.C.A. § 68-11-1625.

The following questions are listed according to the four criteria: (1) Need, (2) Economic Feasibility, (3) Applicable Quality Standards, and (4) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper, single-sided.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer, unless specified otherwise. ***If a question does not apply to your project, indicate "Not Applicable (NA)."***

APPLICANT'S ANALYSIS OF THE NEED FOR THE PROJECT

This project has been designed to meet the needs and expectations of patients and physicians who are choosing to utilize TriStar StoneCrest's north Rutherford County campus for acute care. The need for the project is driven and supported by four main factors:

Factor 1: Existing ambulatory surgical centers in StoneCrest's Primary Service Area Already Meet the State Health Plan Criterion for Adding Operating Room Capacity to the Service Area.

The surging populations in and near Rutherford County have filled the project service area's comparable surgery center's average O.R. utilization to beyond the 70% "optimal" threshold that the State Health Plan recommends for approval of additional capacity.

The most current available data from the eight "comparable" existing facilities, for CY 2016, demonstrates the following:

- The project's primary service area is defined by 1.5 years of surgical outpatient origin at StoneCrest Medical Center for the medical specialties to be offered in this facility. The primary service area is designated as ten zip codes covering parts of Rutherford, southeast Davidson, and east Williamson Counties.

- In that primary service area, there will be six ASTC's that provide services in the eight specialties projected for the StoneCrest Surgery Center. (A seventh ASTC has been inactive until several months ago and it has been granted CON approval to move outside this project's primary service area into zip code 37207.

- Only three of these six surgery centers are multi-specialty facilities like StoneCrest's proposed project. One of the other three is a private-practice podiatry facility that only performed 44 cases last year and cannot reasonably be considered a community resource comparable to the other centers. There is also an endoscopy center and an orthopedic center.

- 94% of the O.R.'s in this service area are in the five facilities other than the podiatry center. Their average O.R. utilization exceeded 77% last year. The three multispecialty centers alone averaged 77%. Even the entire six-facility group average was almost 73%. No matter how grouped, last year the existing ASTC's in the defined project service area significantly exceeded the State Health Plan's criterion of 70% areawide O.R. utilization, at which additional O.R. capacity may be approved.

Supplemental Table: 2016 Utilization of Comparable Surgery Centers in the Primary Service Area
StoneCrest Surgery Center

Zip Code	Zip Code Name	Name of ASTC	Specialty	O.R.'s	O.R. Cases	O.R. % of Full 100% Occy (1263)	O.R. % of Optimal 70% Occy (884)	Proc Rooms	Proc Room Cases	P.R. % of Full 100% Occy (2667)	P.R. % of Optimal 70% Occy (1867)
Rutherford County											
37086	LaVergne	none									
37127	Murfreesboro	none									
37128	Murfreesboro	none									
37129	Murfreesboro	Middle Tennessee Ambulatory Surgery Center	Multi	6	6,214	82.0%	117.2%	1	934	35.0%	50.03%
		Surgicenter of Murfreeesboro Medical Clinic	Multi	3	4,237	111.8%	159.8%	3	6,036	75.4%	107.77%
		Williams Surgery Center	Podiatry	1	44	3.5%	5.0%	0	0	0.0%	0.00%
37130	Murfreesboro	Mid-State Endoscopy Center	GI	0	0	0.0%		1	2,395	89.8%	128.28%
37167	Smyrna	Physicians Pavilion Surgery Center	Multi	4	2,183	43.2%	61.7%	1	694	26.0%	37.17%
37013	Antioch	none									
37211	Nashville	Premier Orthopedic Surgery Center	Orthopedics	2	2,029	80.3%	114.8%	0	0	0.0%	
		*Southern Hills Surgery Center	Multi								
37217	Nashville	none									
Williamson County											
37135	Nolensville	none									
		ALL FACILITIES		16	14,707	**72.8%**	104.0%	6	10,059	**62.9%**	89.8%
		** ALL EXCEPT WILLIAMS PODIATRIC		15	14,633	**77.2%**	110.4%	6	10,059	**62.9%**	89.8%
		***ALL EXCEPT WILLIAMS PODIATRIC & PHYSICIANS PAVILION		11	12,480	**89.8%**	128.3%	4	9,365	**87.8%**	125.4%
		ALL MULTISPECIALTY FACILITIES		13	12,634	**76.9%**	109.9%	5	7,664	**57.5%**	82.1%

* CON approved to move So Hills ASTC out of PSA; no 2016 JAR; license was in abeyance
** 94% of O.R. capacity is in this group
***69% of O.R. capacity is in this group

Supplemental 1

23R3

Factor 2. Surgery Center utilization in Rutherford County Will Continue to Increase.

• Multispecialty facilities are the most appropriate type of surgery center to consider in projecting future area needs. Single-specialty facilities are often private practice facilities with very limited medical staff and a narrow scope of service. The service area's need is better indicated by facilities with larger service scope and medical staff depth.

• The three multispecialty facilities in the project service area are all in fast-growing Rutherford County. Joint Annual Report Data for 2011-2016 indicates that they had a 19.2% increase in O.R. cases in the five years from 2011 to 2016. This far exceeded the overall increase of 12.2% for all area surgery centers.

• If the same historic 5-year O.R. case growth rate is projected to 2021 (the second year of operation for StoneCrest Surgery Center) it indicates that these three facilities can share approximately 15,060 O.R. cases. They have 13 O.R.s. That would give them a group average of 1,158 O.R. cases per O.R.--131% above the 884 cases that the State Health Plan defines as optimal 70% utilization of an O.R. StoneCrest Surgery Center, with a different staff of surgeons, will obtain most of its O.R. cases from different referral patterns, and from recruitment of new surgeons.

• There are additional indicators of strong growth in demand for surgery center O.R. capacity in this market, emanating from the Federal level. CMS (Medicare) is currently proposing to add three surgical procedures to the ASC covered procedures list (CPL). (i.e., to reimburse them if done in a surgery center). More significantly, CMS is soliciting public comment on whether several joint replacement surgeries--total knee arthroplasty, partial hip arthroplasty, and total hip arthroplasty--meet the criteria to be added to the ASC-CPL. These are high-volume cases that currently are reimbursed only in a hospital setting. If approved for surgery centers, as many anticipate, the need of patients, employers, and insurors (including Medicare) to reduce their costs of care will drive new demand for surgery center O.R. time.

• Published materials in the application's first attachment provide a government and industry-wide perspective on the extraordinarily large savings that are accruing to both patients and insurors (including Medicare) as inpatient or hospital outpatient department (HOPD) surgeries are moved to ambulatory surgery centers. This is causing hospital organizations across the country to establish their own affiliated, quality-controlled surgery centers for their own patients. The StoneCrest Surgery Center project is a necessity for service area patients and their payors.

SUPPLEMENTAL #1
July 31, 2017
8:27 am

Utilization of Existing Surgery Centers in Primary Service Area (PSA)--2014 to 2016
StoneCrest Surgery Center

PSA Zip Code / Primary County	ASTC	2011		2014		2015		2016	
		O.R. Cases	P.R. Cases	O.R. Cases	P.R. Cases	O.R. Cases	P.R. Cases	O.R. Cases	P.R. Cases
37129 - Murfreesboro	Middle Tennessee Ambulatory Surgery Center	5,800	464	5,609	666	5,837	873	6,214	934
	Surgicenter of Murfreesboro Medical Clinic	3,100	4,555	3,729	5,138	4,034	5,456	4,237	6,036
	Williams Surgery Center (Podiatry)	127	0	67	0	56	0	44	0
37130 - Murfreesboro	Mid-State Endoscopy Center	0	134	0	3,209	0	2,160	0	2,395
37167 - Smyrna	Physicians Pavilion Surgery Center	1,698	752	2,272	551	1,991	568	2,183	694
37211 - Nashville	Premier Orthopedic Surgery Center	2,382	0	2,543	0	2,165	0	2,029	0
		13,107	**5,905**	14,220	9,564	14,083	9,057	**14,707**	**10,059**
		All Six ASC's in PSA		O.R. Case Increase over 5 years				12.2%	

Supplemental 1

Three Existing Multispecialty Surgery Centers in PSA--Three and Five Year History of O.R. Cases
StoneCrest Surgery Center

Zip	Multispecialty Only		OR cases 2011		OR cases 2014				OR cases 2016
37129	Middle Tennessee Ambulatory Surgery Center		5,800		5,609				6,214
37129	Surgicenter of Murfreeesboro Medical Clinic		3,100		3,729				4,237
37167	Physicians Pavilion Surgery Center		1,698		2,272				2,183
			10,598		11,610				12,634
								3 yr chge 2014-16	8.8%
								5 yr chge 2011-16	19.2%

Projected Total Cases of Existing Multispecialty Surgery Cases in PSA
StoneCrest Surgery Center (SCSC)

Projection of Multispecialty Facility Cases		2016	2017	2018	2019	SCSC Yr 1 2020	SCSC Yr 2 2021	SCSC Yr 3 2022
At Three Year Rate of Increase 8.8%		12,634			13,746			14,955
At Five Year Rate of Increase 19.2%		12,634					15,060	

Additional Cases	
2321	By Yr 3
2426	By Yr 2

Supplemental 1

Factor 3: Rapid population growth in this area will require acute care providers to offer more ambulatory surgery capacity in this decade.

• The StoneCrest acute care campus is in Rutherford County. More than 74% of StoneCrest's outpatient surgery patients are residents of Rutherford County. Rutherford County has the fastest-growing population of any county in Tennessee, according to current four-year projections by the Tennessee Department of Health. The county's growth rate is the State's only double-digit rate. The county is projected to increase in population by 11.9% between now and CY 2021. This is 280% of the projected Statewide population growth (4.2%) in that time period.

Moreover, Rutherford County is experiencing that growth on a population base that is already very large. It is Tennessee's fifth most populous county, having already more than 150% of the population of adjoining Williamson County. Rutherford County's population is projected to be almost equal to that of Chattanooga/Hamilton County in four more years.

• Rapid growth is not confined to the Rutherford County portion of StoneCrest's primary service area. This project's primary service area ("PSA") consists of ten zip codes in Rutherford County and nearby parts of Southeast Davidson County and eastern Williamson County that generate approximately 83% of StoneCrest's outpatient surgery cases in the eight main specialties that will use this surgery center. Those zip codes are increasing significantly in population. Commercial population projections indicate that over the next four years, their adult population will increase by 7.5%, much faster than the Department of Health's forecast rate of 4.2% Statewide. Commercial sources project that these zip codes' elderly population will increase by 27.1% in the next four years. By contrast, the Department of Health projects that the Statewide elderly population will increase by only 15.8% during that period.

This growth will continue to fuel demand for steadily increasing acute care service capacity. Recruitment of additional physicians will be necessary to meet these demands. This project will be particularly helpful to StoneCrest Medical Center in recruiting new surgeons to the north Rutherford County community.

Factor 4: The Project Meets an Area Need for Continued Diversification in Patient Care Options.

Patients and their physicians have evolving and reasonable expectations of acute care providers:

- They are asking for simpler and more efficient processes and paperwork in acute care settings.
- They need to lower their costs of care.
- Surgeons want a stronger voice in operation of their surgical suites.
- Many patients would like to avoid the risks of entering hospital buildings where new drug-resistant infections are becoming more of an issue than in past years.

The public and the medical staff need these reasonable options. Being able to use a hospital-affiliated, quality-controlled freestanding ambulatory surgery center addresses all of those concerns and preferences. It is increasingly attractive to patients and to their surgeons.

HCA affiliates operate four general acute care hospitals in Davidson County, and three of them have already acquired or established hospital-affiliated, physician joint-ventured ambulatory surgery centers to provide their patients and medical staff with this attractive option.

In Rutherford County, the only acute care hospital other than StoneCrest has already received CON approval for two affiliated surgery centers and is proposing a third one.

This project affirms TriStar StoneCrest's commitment to move in a similar direction. Having attempted unsuccessfully for some time now to acquire an existing surgery center in its primary service area, the hospital is now requesting approval to construct an ambulatory surgery center on its own campus, to provide this important option for its patients, physicians, and community.

APPLICATION FORM PART B QUESTIONS

NEED

1. Provide a response to each criterion and standard in Certificate of Need categories in the State Health Plan that are applicable to the proposed project. Criteria and standards can be obtained from the THSDA or found on the agency's website at http://tjn.gov/hsda/article/hsda-criteria-and-standards.

STATE HEALTH PLAN
CERTIFICATE OF NEED STANDARDS AND CRITERIA
FOR
AMBULATORY SURGICAL TREATMENT CENTERS

Assumptions in Determination of Need
The need for an ambulatory surgical treatment center shall be based upon the following assumptions:

1. Operating Rooms

a. An operating room is available 250 days per year, 8 hours per day.

The StoneCrest Surgery Center's operating rooms will be available for scheduled surgeries Monday through Friday, 250 days per year, for 8 hours per day.

b. The estimated average time per Case in an Operating Room is 65 minutes.
c. The average time for clean up and preparation between Operating Room Cases is 30 minutes.

These two criteria allow for an average of 95 minutes per case, including case time and room turnaround time. The StoneCrest Surgery Center is projected to average 92 minutes per operating room case. Please see the following table for a time analysis of cases in the operating rooms of the project, and also for the hospital.

d. The optimum utilization of a dedicated, outpatient, general-purpose Operating Room is 70% of full capacity. 70% x 250 days/year x 8 hours/day divided by 95 minutes = 884 Cases per year.

As shown on the second following page, the facility's two O.R.'s are projected to operate at approximately 57% occupancy in Year Two, performing 1,493 cases. This level of service justifies having more than one O.R. A single O.R. has only 120,000 available minutes of schedulable time in a normal work year. The cases at this center in Year Two are projected to require 137,005 minutes.

Supplemental Table: Surgical Room Utilization Year Two (CY 2021)
StoneCrest Surgery Center (Revised 7-31-17)

Surgical Rooms	Cases	Cases/Room	Average Room Minutes Used/Case	Average Turnaround Minutes/Case	Average Total Minutes Per Case	Total Minutes Required for Projected Cases	Schedulable Minutes of Room Capacity*	Utilization % of Schedulable Minutes (120,000 Minutes)	Utilization % of Optimal Utilization OR = 884 PR = 1,867
Operating Room #1	747	747	72.0	15.0	87.0	64,946	120,000	54.1%	84.4%
Operating Room #2	746	746	72.0	15.0	87.0	64,902	120,000	54.1%	84.4%
O.R's Subtotal	1,493	746.5	72.0	15.0	87.0	129,891	240,000	54.1%	84.4%
Procedure Room	515	515	20	7	27	13,905	120,000	11.6%	27.6%
Total Surgical Suite	*2,008*	*669*	*61*	*16*	71.6	*143,796*	*360,000*	39.9%	*55.2%*

** 8 hours X 250 days X 60 minutes per hour = 120,000 Schedulable Minutes = SHP standard for 100% Utilization of a surgical room.*

Note: Case minute data are approximate due to roundings in calculations, and will not total exactly to total required case minutes that are taken from specialty-specific table.

Supplement 1

StoneCrest Medical Center Surgical Suite Case and Turnaround Times 2016 and 2017 Annualized

Surgical Suite Utilization by Case and Turnaround Times, CY2016

	Number of Rooms	IP + OP Cases 2016	Avge Cases/Rm 2016	Total Surg Minutes * 2016	Average Room Turnaround Minutes/Case 2016	Total Turnaround Minutes 2016	Minutes Room in Use 2016	Annual Schedulable Minutes	Room Utilization Percent 2016
O.R.s	8	4,026	503	392,085	44	177,144	569,229	960,000	59.3%
Endo Rooms	3	2,884	961	91,707	12	34,608	126,315	360,000	35.1%
Subtotals	*11*	*6,910*	*628*	*483,792*		*211,752*	*695,544*	*1,320,000*	*52.7%*
Cysto Rooms	0	0	0	0	0	0	0	0	
Other Rooms	0	0	0	0	0	0	0	0	0.0%
Total All Rooms	*11*	*6,910*	*628*	*483,792*		*211,752*	*695,544*	*1,320,000*	*52.7%*

Surgical Suite Utilization by Case and Turnaround Times, Q1-Q2 2017 ANNUALIZED

	Number of Rooms	IP + OP Cases 2017A	Avge Cases/Rm 2017A	Total Surg Minutes * 2017A	Average Room Turnaround Minutes/Case 2071A	Total Turnaround Minutes 2017A	Minutes Room in Use 2017A	Annual Schedulable Minutes	Room Utilization Percent 2017A
O.R.s	8	4,378	547	426,543	44	192,632	619,175	960,000	64.5%
Endo Rooms	3	3,448	1,149	100,135	14	48,272	148,407	360,000	41.2%
Subtotals	*11*	*7,826*	*711*	*526,678*		*240,904*	*767,582*	*1,320,000*	*58.2%*
Cysto Rooms	0	0		0	0	0	0	0	
Other Rooms	0	0	0	0	0	0	0	0	0.0%
Total All Rooms	*11*	*7,826*	*711*	*526,678*		*240,904*	*767,582*	*1,320,000*	*58.2%*

**minutes patients were in the O.R. ("wheel-in through wheel-out")*
***TA = room turnaround minutes based on time between Out OR and In OR times in the same room on the same day.*

Note: This table assumes that all OR's are used for both IP and OP cases.

Actual and Projected Surgical Cases 2013-2021
StoneCrest Medical Center and StoneCrest Ambulatory Surgical Treatment Center

STONECREST MEDICAL CENTER	Actual 2013	Actual 2014	Actual 2015	Actual 2016	Ann'd 2017	Projected 2018	Projected 2019	Projected 2020	Projected 2021
# Operating Rooms	8	8	8	8	8	8	8	8	8
# Procedure Rooms	3	3	3	3	3	3	3	3	3
Total Rooms	11	11	11	11	11	11	11	11	11
Cases in Operating Rooms	4,680	4,440	4,351	4,086	4,378	4,540	4,708	3,433	3,570
IP	1,032	1,061	998	1,115	1,278	1,316	1,355	1,396	1,438
OP	3,648	3,379	3,353	2,971	3,100	3,224	3,353	2,037	2,132
Cases/O.R.	425	404	396	371	398	413	428	312	325
Cases in Procedure Rooms	1,596	1,762	2,326	2,884	3,448	3,583	3,724	3,370	3,506
IP	229	221	224	254	310	319	329	339	349
OP	1,367	1,541	2,102	2,630	3,138	3,264	3,395	3,031	3,157
Cases/Proc Rm	532	587	775	961	1,149	1,194	1,241	1,123	1,169
Total Hospital Cases	6,276	6,202	6,677	6,970	7,826	8,123	8,432	6,803	7,076
Annual Case Growth Rate		-1.2%	7.7%	4.4%	12.3%	3.8%	3.8%	-19.3%	4.0%

STONECREST SURGERY CENTER	Projected Yr 1 2020	Projected Yr 2 2021
# Operating Rooms	2	2
# Procedure Rooms	1	1
Total Rooms	3	3
Cases in Operating Rooms	1,450	1,493
Cases/O.R.	725	747
Cases in Procedure Rooms	500	515
Cases/Proc Rm	500	515
Total ASTC Cases	1,950	2,008
Annual Case Growth Rate		3.0%

STONECREST CAMPUS									
Total Campus Outpatient Cases	5,015	4,920	5,455	5,601	6,238	6,488	6,748	7,018	7,297
Annual OP Case Growth Rate		-1.9%	10.9%	2.7%	11.4%	4.0%	4.0%	4.0%	4.0%
Total Campus Cases--IP & OP	6,276	6,202	6,677	6,970	7,826	8,123	8,432	8,753	9,084
Annual IP + OP Case Growth Rate		-1.2%	7.7%	4.4%	12.3%	3.8%	3.8%	3.8%	3.8%

Source: 2015-2016 data from Joint Annual Report. 2017+ data from hospital management and records.

2. Procedure Rooms

a. A procedure room is available 250 days per year, 8 hours per day.

The StoneCrest Surgery Center's procedure room will be available for scheduled surgeries Monday through Friday, 250 days per year, for 8 hours per day.

b. The estimated average time per outpatient Case in a procedure room is 30 minutes.
c. The average time for clean up and preparation between Procedure Room Cases is 15 minutes.

These two criteria allow for an average of 45 minutes per case, including case time and room turnaround time. The StoneCrest Surgery Center is projected to average 37 minutes per operating room case. Please see the table above, on the second preceding page, for a time analysis of cases in the procedure room.

d. The optimum utilization of a dedicated, outpatient, general-purpose outpatient Procedure Room is 70% of full capacity. 70% x 250 days/year x 8 hours/day divided by 45 minutes = 1867 Cases per year.

The procedure room is projected to perform 515 cases in Year Two. However, as stated in the State Health Plan paragraph immediately below, this review criterion recognizes that a project not meeting the 1,867-case standard may nonetheless have a need for one procedure room. This type of facility needs a procedure room for gastroenterology endoscopy procedures, which are non-sterile surgeries not appropriate to perform in a sterile O.R.

Determination of Need

1. Need. The minimum numbers of 884 Cases per Operating Room and 1867 Cases per Procedure Room are to be considered as baseline numbers for purposes of determining Need. An applicant should demonstrate the ability to perform a minimum of 884 Cases per Operating Room and/or 1867 Cases per Procedure Room per year, except that an applicant may provide information on its projected case types and its assumptions of estimated average time and clean up and preparation time per Case if this information differs significantly from the above-stated assumptions. It is recognized that an ASTC may provide a variety of services/Cases and that as a result the estimated average time and clean up and preparation time for such services/Cases may not meet the minimum numbers set forth herein. It is also recognized that an applicant applying for an ASTC Operating Room(s) may apply for a Procedure Room, although the anticipated utilization of that Procedure Room may not meet the base guidelines contained here. Specific reasoning and explanation for the inclusion in a CON application of such a Procedure Room must be provided. An applicant that desires to limit its Cases to a specific type or types should apply for a Specialty ASTC.

The procedure room is projected to perform 515 cases in Year Two. However, as stated in the paragraph immediately above, the State Health Plan criteria recognize that a project not meeting the 1,867-case standard may nonetheless have a need for one procedure room. This type of facility needs a procedure room for gastroenterology endoscopy procedures, which are non-sterile surgeries not appropriate to mix with cases requiring a sterile O.R.

2. Need and Economic Efficiencies. An applicant must estimate the projected surgical hours to be utilized per year for two years based on the types of surgeries to be performed, including the preparation time between surgeries. Detailed support for estimates must be provided.

The tables on the third preceding page shows the proposed surgery center's projected cases, time requirements, and room utilization percentages, for both the O.R.s and the procedure room. Those projections are based on the experience of Medical Care America, LLC, the entity involved in planning this StoneCrest project, in collaboration with StoneCrest Medical Center. Medical Care America manages 133 surgery centers across the nation.

The projections indicate that the facility's two O.R.'s will operate at approximately 57% occupancy in Year Two, performing 1,493 cases. This level of service justifies having more than one O.R. A single O.R. has only 120,000 available minutes of schedulable time in a normal work year. The cases at this center in Year Two are projected to require 137,005 minutes.

Also, the State Plan review criteria do not require that the entire O.R. suite must reach 70% utilization in Year Two. It would be inappropriate to plan an expensive healthcare facility with only as much capacity as would be 70% full within twenty-four months of completion. Acute care construction planning rarely, if ever, adopts such a short time horizon.

3. Need; Economic Efficiencies; Access. To determine current utilization and need, an applicant should take into account both the availability and utilization of either: a) all existing outpatient Operating Rooms and Procedure Rooms in a Service Area, including physician office based surgery rooms (when those data are officially reported and available) OR b) all existing comparable outpatient Operating Rooms and Procedure Rooms based on the type of Cases to be performed. Additionally, applications should provide similar information on the availability of nearby out-of-state existing outpatient Operating Rooms and Procedure Rooms, if that data are available, and provide the source of that data. Unstaffed dedicated outpatient Operating Rooms and unstaffed dedicated outpatient Procedure Rooms are considered available for ambulatory surgery and are to be included in the inventory and in the measure of capacity.

The responses to criteria 4 and 5 below provide an inventory and 2016 utilization statistics of all existing comparable ambulatory surgical facilities in the project's service areas. Comparable facilities are defined as ambulatory surgical treatment centers offering the same types of specialized surgeries that this project will offer. Please see those sections for further information. The applicant knows of no out-of-State surgical rooms, or rooms unstaffed or unimplemented, that will be located in the project service area, when this facility opens in 2020.

4. Need and Economic Efficiencies. An applicant must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON application to establish an ASTC or to expand existing services of an ASTC should not be approved unless the existing ambulatory surgical services that provide *comparable services regarding the types of Cases performed*, if those services are known and relevant, within the applicant's proposed Service Area *or within the applicant's facility* are demonstrated to be currently utilized at 70% or above.

The project's primary service area--defined by actual surgical outpatient origin at StoneCrest Medical Center--extends into three counties: Rutherford, southeast Davidson, and east Williamson Counties. The tables on the following two pages, taken from a later part of this application, demonstrate the following:

a. In the primary service area, there will be six ASTC's that perform surgeries in the eight surgical specialties projected for the StoneCrest Surgery Center. (A seventh has been inactive until recently; it has filed no Joint Annual Report for 2016; and it has final CON approval to move outside this project's primary service area to zip code 37127).

b. Only three of the six surgery centers are multi-specialty facilities like StoneCrest's proposed project. One of the other three is a private-practice podiatry facility that only performed 44 cases last year and cannot reasonably be considered a community resource comparable to the other centers. There are also a busy endoscopy center and a busy orthopedic center.

c. 94% of the O.R.'s in this service area are in the five facilities *other than* the podiatry center. Those five centers' average O.R. utilization exceeded 77% last year.

The three multispecialty centers alone averaged 77%.

The entire group of six surgery centers averaged utilization of almost 73%.

No matter how grouped, last year the existing ASTC's in the defined project service area significantly exceeded the State Health Plan's criterion of 70% service area O.R. utilization, at which additional O.R. capacity may be approved.

d. The three multispecialty facilities in the project service area are all in fast-growing Rutherford County. Joint Annual Report Data for 2011-2016 indicates that they had a 19.2% increase in O.R. cases in the five years from 2011 to 2016. This far exceeded the overall increase of 12.2% for all area surgery centers.

e. If the same historic 5-year O.R. case growth rate is projected to 2021 (the second year of operation for StoneCrest Surgery Center) it indicates that these three facilities can share approximately 15,060 O.R. cases. They have 13 O.R.s. That would give them a group average of 1,158 O.R. cases per O.R.--131% above the 884 cases that the State Health Plan defines as optimal 70% utilization of an O.R. StoneCrest Surgery Center, with a different staff of surgeons, will obtain most of its O.R. cases from different referral patterns, and from recruitment of new surgeons.

f. The StoneCrest Surgery Center project is unlikely to have a significant adverse impact on existing area surgery centers. The cases projected for StoneCrest Surgery Center are based on outpatient case volumes currently in StoneCrest Medical Center's surgical suites, increased annually at a small percentage that is lower than the 2015-2017 growth rate of outpatient cases at the hospital.

g. Over the next decade, as indicated by published materials in the first attachment to the application, there will be irresistible incentives for employers, patients, and payors (including but limited to Medicare) to cause the migration of more hospital-based surgery cases into licensed surgery centers. This will continue to feed increases in surgery center utilization over the next ten years.

Supplemental Table: 2016 Utilization of Comparable Surgery Centers in the Primary Service Area
StoneCrest Surgery Center

Zip Code	Zip Code Name	Name of ASTC	Specialty	O.R.'s	O.R. Cases	O.R. % of Full 100% Occy (1263)	O.R. % of Optimal 70% Occy (884)	Proc Rooms	Proc Room Cases	P.R. % of Full 100% Occy (2667)	P.R. % of Optimal 70% Occy (1867)
Rutherford County											
37086	LaVergne	none									
37127	Murfreesboro	none									
37128	Murfreesboro	none									
37129	Murfreesboro	Middle Tennessee Ambulatory Surgery Center	Multi	6	6,214	82.0%	117.2%	1	934	35.0%	50.03%
		Surgicenter of Murfreeesboro Medical Clinic	Multi	3	4,237	111.8%	159.8%	3	6,036	75.4%	107.77%
		Williams Surgery Center	Podiatry	1	44	3.5%	5.0%	0	0	0.0%	0.00%
37130	Murfreesboro	Mid-State Endoscopy Center	GI	0	0	0.0%		1	2,395	89.8%	128.28%
37167	Smyrna	Physicians Pavilion Surgery Center	Multi	4	2,183	43.2%	61.7%	1	694	26.0%	37.17%
37013	Antioch	none									
37211	Nashville	Premier Orthopedic Surgery Center	Orthopedics	2	2,029	80.3%	114.8%	0	0	0.0%	
		*Southern Hills Surgery Center	Multi								
37217	Nashville	none									
Williamson County											
37135	Nolensville	none									
		ALL FACILITIES		16	14,707	**72.8%**	104.0%	6	10,059	**62.9%**	89.8%
		** ALL EXCEPT WILLIAMS PODIATRIC		15	14,633	**77.2%**	110.4%	6	10,059	**62.9%**	89.8%
		***ALL EXCEPT WILLIAMS PODIATRIC & PHYSICIANS PAVILION		11	12,480	**89.8%**	128.3%	4	9,365	**87.8%**	125.4%
		ALL MULTISPECIALTY FACILITIES		13	12,634	**76.9%**	109.9%	5	7,664	**57.5%**	82.1%

* CON approved to move So Hills ASTC out of PSA; no 2016 JAR; license was in abeyance
** 94% of O.R. capacity is in this group
***69% of O.R. capacity is in this group

Supplemental 1

36R3

5. Need and Economic Efficiencies. An application for a Specialty ASTC should present its projections for the total number of cases based on its own calculations for the projected length of time per type of case, and shall provide any local, regional, or national data in support of its methodology. An applicant for a Specialty ASTC should provide its own definitions of the surgeries and/or procedures that will be performed and whether the Surgical Cases will be performed in an Operating Room or a Procedure Room. An applicant for a Specialty ASTC must document the potential impact that the proposed new ASTC would have upon the existing service providers and their referral patterns. A CON proposal to establish a Specialty ASTC or to expand existing services of a Specialty ASTC shall not be approved unless the existing ambulatory surgical services that provide comparable services regarding the types of Cases performed within the applicant's proposed Service Area or within the applicant's facility are demonstrated to be currently utilized at 70% or above. An applicant that is granted a CON for a Specialty ASTC shall have the specialty or limitation placed on the CON.

This criterion appears not to be relevant to a proposed multispecialty surgery center.

Other Standards and Criteria

6. Access to ASTCs. The majority of the population in a Service Area should reside within 60 minutes average driving time to the facility.

Complies. See drive time tables below. Virtually all of the primary service area population lives within less than an hour's drive time of the project site.

Mileage and Drive Times Between Project and Major Communities in the Primary Service Area			
City	**County**	**Distance**	**Drive Time**
1. Murfreesboro	Rutherford	15.8 miles	22 minutes
2. LaVergne	Rutherford	4.9 miles	12 minutes
3. Antioch	Davidson	7.5 miles	11 minutes
4. Nolensville	Williamson	7.4 miles	15 minutes

7. Access to ASTCs. An applicant should provide information regarding the relationship of an existing or proposed ASTC site to public transportation routes if that information is available.

At this time, there is no municipal or county bus service to the campus of TriStar StoneCrest Medical Center, where this surgery center will be located.

8. Access to ASTCs. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must
• project the origin of potential patients by percentage and county of residence and, if such data are readily available, by zip code, and
• must note where they are currently being served.
• Demographics of the Service Area should be included, including the anticipated provision of services to out-of-state patients, as well as
• the identity of other service providers both in and out of state and the source of out-of-state data. Applicants shall document all other provider alternatives available in the Service Area.
• All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

Patient Origin:

The StoneCrest Surgery Center's surgical patient origin experience for its own outpatient cases in 2015 through YTD 2017 has been used to forecast patient origin by primary service area zip codes.

Projected Patient Origin StoneCrest Surgery Center				
Zip Code and Name	Primary County	Projected Percent of Total Cases	Year One Cases (2020)	Year Two Cases (2021)
37167--Smyrna	Rutherford	33.1%	646	665
37086--LaVergne	Rutherford	16.0%	311	320
37129--Murfreesboro	Rutherford	9.2%	179	185
37013--Antioch	Davidson	7.4%	144	148
37128--Murfreesboro	Rutherford	6.8%	133	137
37130--Murfreesboro	Rutherford	4.5%	87	89
37127--Murfreesboro	Rutherford	1.8%	35	36
37211--Nashville	Davidson	1.6%	30	31
37135--Nolensville	Williamson	1.5%	29	30
37217--Nashville	Davidson	1.2%	24	25
(Subtotal)		*83.0%*	*1,618*	*1,666*
	Other States & Cos*	*17.0%*	*332*	*342*
Grand Total			*1,950*	*2,008*

**220 zip codes in 17 States contributed less than 1.2% of hospital's outpatient surgery cases in the 8 specialties during 2016-2017.*
Source: Facility records, 2015 through Q1-Q2 2017.

Where These Patients Are Now Served:

These patients currently are being served by StoneCrest Medical Center.

Service Area Demographics:

This is provided in Table B-Need-4A(2) of the application.

Service Area Providers:

They are identified in the responses to Section B-Need-State Health Plan-4, located above in this section. The service area will have six surgery centers.

Assumptions--Each section's responses identifies its assumptions and sources of data.

9. Access and Economic Efficiencies. An application to establish an ambulatory surgical treatment center or to expand existing services of an ambulatory surgical treatment center must project patient utilization for each of the first eight quarters following completion of the project. All assumptions, including the specific methodology by which utilization is projected, must be clearly stated.

The quarterly projection table below distributes the annual case projections made in other sections of this application. It reflects StoneCrest Medical Center's recent experience with the quarterly volume variances with its outpatient surgeries.

StoneCrest Surgery Center Year One and Year Two Projected Cases by Quarter					
	Q1 Cases	Q2 Cases	Q3 Cases	Q4 Cases	Total
2020	459	493	480	518	1,950
2021	473	508	494	533	2,008

10. Patient Safety and Quality of Care; Health Care Workforce.

a. An applicant should be or agree to become accredited by any accrediting organization approved by the Centers for Medicare and Medicaid Services, such as the Joint Commission, the Accreditation Association of Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgical Facilities, or other nationally recognized accrediting organization.

The applicant will seek AAAHC accreditation.

b. An applicant should estimate the number of physicians by specialty that are expected to utilize the facility and the criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel. An applicant should provide documentation on the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.

StoneCrest Surgery Center anticipates the following active surgical staff members by specialty, whether or not they participate in the syndication.

	Estimated Active Medical Staff Year One
Gastroenterology	2
General Surgery	4
Gynecology	5
Orthopedics	5
Otolaryngology (ENT)	2
Plastic Surgery	1
Podiatry	3
Urology	3
Total	**25**

Anesthesia will likely be provided by Nashville Anesthesia Services, whose letter of interest and commitment is provided in the Attachments.

11. Access to ASTCs. In light of Rule 0720-11.01, which lists the factors concerning need on which an application may be evaluated, and Principle No. 2 in the State Health Plan, *"Every citizen should have reasonable access to health care,"* the HSDA may decide to give special consideration to an applicant:

a. Who is offering the service in a medically underserved area as designated by the United States Health Resources and Services Administration;

Parts of the service area are Federally designated as medically underserved areas. They are identified in Attachment B-Need-State Health Plan-11a.

b. Who is a "safety net hospital" or a "children's hospital" as defined by the Bureau of TennCare Essential Access Hospital payment program;

Not applicable.

c. Who provides a written commitment of intention to contract with at least one TennCare MCO and, if providing adult services, to participate in the Medicare program;

The applicant so commits. The applicant will seek contracts with Medicare and with all area TennCare MCO's. This is standard policy for all HCA-affiliated acute care providers in Tennessee.

d. Who is proposing to use the ASTC for patients that typically require longer preparation and scanning times. The applicant shall provide in its application information supporting the additional time required per Case and the impact on the need standard.

Not applicable. The applicant's case times are not longer than the criteria.

2. Describe the relationship of this project to the applicant facility's long-range development plans, if any, and how it relates to previously approved projects of the applicant.

The applicant and its affiliate TriStar Health System have been planning and developing this type of project for several years, with three such hospital-affiliated facilities already in operation in Middle Tennessee. The reasons for it have been set forth in preceding sections of the application. In 2014 StoneCrest began attempting to acquire existing ASTC capacity in its service area, but to date this has not been successful (details are not available due to financial non-disclosure agreements among the affected providers). The new construction alternative must now be pursued.

The project ownership team agrees with materials in the first appendix to this application, which document that overwhelming cost savings opportunities are now causing hospital-based outpatient surgeries to be moved into separately licensed ambulatory surgery centers at an increasing rate over the next decade. The potential savings to patients, employers, and insurors (including Medicare) are very significant.

The CON process must utilize State data that is more than a year old, and the process asks for two-year utilization and financial projections for applicants. However, acute care hospitals like StoneCrest must plan for area needs five to ten years into the fututre, in their decisions to allocate resources to establish or purchase major facilities such as surgical facilities.

3. Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map for the Tennessee portion of the service area, using the map on the following page, clearly marked to reflect the service area as it relates to meeting the requirements for CON criteria and standards that may apply to the project. Please include a discussion of the inclusion of counties in the bordering states, if applicable.

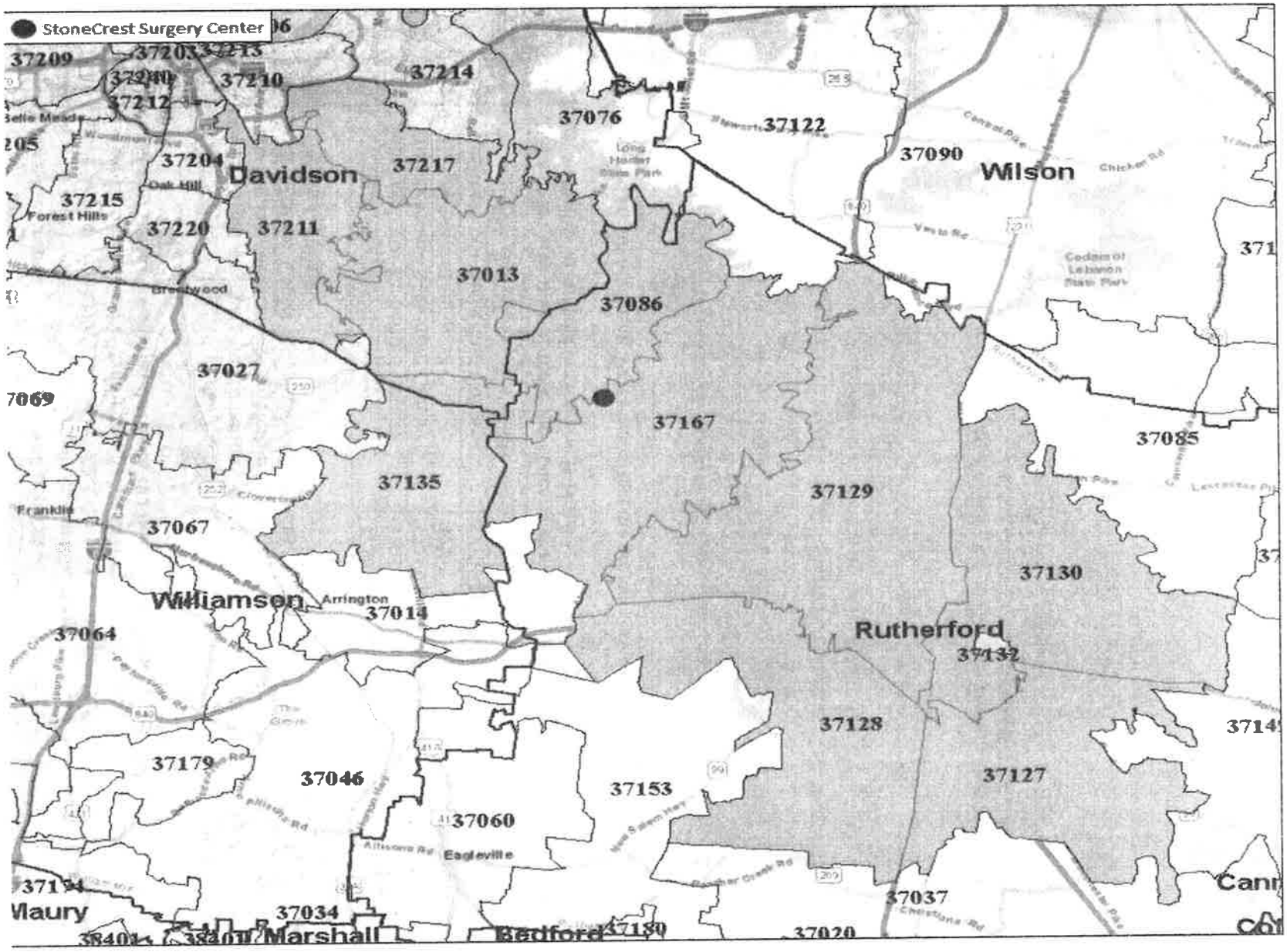
The facility's declared primary service area, from which 83% of its cases will originate, will consist of ten zip codes in Rutherford, southeast Davidson, and east Williamson County. These are the zip codes that have contributed 83% of outpatient surgical cases performed at StoneCrest Medical Center in the past 18 months, in the eight surgical specialties identified above. The zip codes are:

37086 Lavergne--Rutherford County	37167 Smyrna--Rutherford County
37127 Murfreesboro--Rutherford County	37013 Antioch--Davidson County
37128 Murfreesboro--Rutherford County	37211 Nashville--Davidson County
37129 Murfreesboro--Rutherford County	37217 Nashville--Davidson County
37130 Murfreesboro--Rutherford County	37135 Nolensville-Williamson County

A service area map of these zip codes, and a county-level map, are provided following this page, as well as in Attachment Section B-Need-3.

There are no bordering States that affect the project service area.

StoneCrest Surgery Center Primary Service Area



3. (Continued) Please complete the following tables, if applicable:

The following data is for Year One (CY2020) of the facility. The first table is by zip codes. The second table shows the PSA counties that contain the primary service area zip codes; and projected utilization by county residents *who live within the PSA zip codes*. The third table is utilization of the project by all residents of the three counties containing the PSA zip codes.

Primary Service Area Zip Codes	Projected Utilization by Zip Code Residents	% of Total Cases
37167--Smyrna	646	33.1%
37086--LaVergne	311	16.0%
37129--Murfreesboro	179	9.2%
37013--Antioch	144	7.4%
37128--Murfreesboro	133	6.8%
37130--Murfreesboro	87	4.5%
37127--Murfreesboro	35	1.8%
37211--Nashville	30	1.5%
37135--Williamson	29	1.6%
37217--Nashville	24	1.2%
PSA Subtotals	*1,618*	*83.0%*
Other Zip Codes & States	*332*	*17.0%*
All Zip Codes	*1,950*	*100.0%*

Counties Containing Primary Service Area Zip Codes	Projected Utilization by County Residents Living in PSA Zip Codes	% of PSA Total Cases
Rutherford	1,391	71.3%
Davidson	198	10.2%
Williamson	29	1.5%
Totals	*1,618*	*83.0%*

Counties Containing Primary Service Area Zip Codes	Projected Utilization by All County Residents	% of ASTC Total Cases
Rutherford	1,391	74.0%
Davidson	198	12.4%
Williamson	29	3.0%
Subtotals	*1,618*	*89.4%*
Other Counties and States	*332*	*11.6%*
Total	*1,950*	*100.0%*

4A(1). Describe the demographics of the population to be served by the proposal.

4A(1). Describe the demographics of the population to be served by the proposal.

The Department of Health projects population growth by county, but not by zip codes. The project is located in Rutherford County, whose population is projected to increase by 11.9% by CY2021, Year Two of this project's operation. The elderly (65+) population, which generates a major percentage of surgery at this campus, is projected to increase by 19.7% by CY2021.

By contrast, the Statewide projected increases in that period are much slower: 4.2% for total population growth and 15.8% for the elderly.

Commercial projections by zip codes from Claritas indicate that the elderly (65+) population in this project's primary service area zip codes will have an increase of 27.2% by CY2021.

Projected Population Increases 2017-2021			
Source	**Area**	**Total Pop. Change**	**65+ Pop. Change**
SG2/Claritas	Primary Service Area Zips	+6.9%	+27.2%
TN Dept of Health	Rutherford County	+11.9%	+19.7%
TN Dept of Health	State of Tennessee	+4.2%	+15.8%

Age and income-related comparisons are as follows:

Age and Income Characteristics				
Area	**Median Age**	**Median Household Income**	**% of Population Living in Poverty**	**TennCare Enrollees as % of Population**
PSA	33.8 years	$58,124	14.0%	Not available
Rutherford Co.	32.9 years	$56,219	12.4%	15.0%
State of TN	38.3 years	$45,219	17.8%	20.5%

A(2). Using current and projected population data from the Department of Health, the most recent enrollee data from the Bureau of TennCare, and demographic information from the U.S. Census Bureau, complete the following table and include data for each county in your proposed service area.

Projected Population Data:

http://www.tn.gov/health/article/statistics-population

TennCare Enrollment Data:

http://www.tn.gov/tenncare/topic/enrollment-data

Census Bureau Fact Finder:

http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml

Please see the table on the following page, which utilized the above sources with respect to the primary service area's demographic analysis on the preceding page.

StoneCrest Surgery Center
Demographic Characteristics of the Primary Service Area Zip Codes
2017-2021

	Department of Health / Health Statistics							Bureau of the Census				TennCare (Not Available on Zip Code Level)	
Primary Service Area Zip Codes	Current Total Population 2017	Projected Total Population 2021	Total Population % Change 2017 - 2021	Projected Population Age 65+ 2017	Projected Population Age 65+ 2021	Projected Population Age 65+ % Change 2017 - 2021	Projected Target* Population Age 65+ As % of Projected Total Population 2021	Median Age	Median Household Income	Persons Below Poverty Level	Persons Below Poverty Level as % of Total Population	Current TennCare Enrollees (06-17)	TennCare Enrollees as % of Total Zip Code Population
37013 Antioch	90,333	96,590	6.9%	6,267	8,616	37.5%	8.9%	31.6	$48,423	12,285	13.6%		
37086 Lavergne	38,180	41,142	7.8%	2,842	3,809	34.0%	9.3%	31.5	$53,672	4,085	10.7%		
37127 Murfreesboro	17,798	19,092	7.3%	2,279	2,864	25.7%	15.0%	35.9	$66,880	2,047	11.5%		
37128 Murfreesboro	55,600	60,818	9.4%	4,871	6,376	30.9%	10.5%	32.4	$60,764	4,114	7.4%		
37129 Murfreesboro	56,471	60,384	6.9%	7,101	8,945	26.0%	14.8%	36.3	$61,930	5,308	9.4%		
37130 Murfreesboro	57,683	61,230	6.1%	6,273	7,400	18.0%	12.1%	29.3	$52,070	13,440	23.3%		
37135 Nolensville	13,530	14,804	9.4%	1,224	1,678	37.1%	11.3%	34.6	$49,322	1,718	12.7%		
37167 Smyrna	56,037	60,314	7.6%	6,075	7,765	27.8%	12.9%	34.9	$103,333	1,849	3.3%		
37211 Nashville	82,471	86,855	5.3%	7,538	9,144	21.3%	10.5%	32.1	$42,392	19,463	23.6%		
37217 Nashville	32,728	34,390	5.1%	2,885	3,627	25.7%	10.5%	33.0	$42,455	6,022	18.4%		
PSA Subtotals	***500,831***	***535,619***	***6.9%***	***47,355***	***60,224***	***27.2%***	***11.2%***	***33.8***	***$58,124.10***	***70,333***	***14.0%***		
State of TN	6,887,572	7,179,512	4.2%	1,133,025	1,312,118	15.8%	18.3%	38.3	$45,219	1,225,988	17.8%	1,412,063	20.5%

Sources: Zp code-Level Population Projections, SG2/Claritas Pop-Facts2017; U.S. Census QuickFacts; TennCare Bureau.
Zip Code Level Population from American Community Survey, U.S. Census Bureau; projections based on 2011-2015 growth rates.
Service area data is either total, or average, as appropriate.

StoneCrest Surgery Center
Demographic Characteristics of Counties Containing the Primary Service Area
2017-2021

	Department of Health / Health Statistics							Bureau of the Census				TennCare	
Counties Containing Parts of Project's Primary Service Area	Current Total Population 2017	Projected Total Population 2021	Total Population % Change 2017 - 2021	Current Population Age 65+ 2017	Projected Population Age 65+ 2021	Projected Population 65+ % Change 2017 - 2021	Projected Population 65+as % of Projected Total Population 2021	Median Age	Median Household Income	Persons Below Poverty Level	Persons Below Poverty Level as % of Total Population	Current TennCare Enrollees (06-17)	TennCare Enrollees as % of Total County or Zip Code Population
Davidson	689,338	722,665	4.8%	80,027	91,284	14.1%	12.6%	34.2	$48,368	125,460	18.2%	139,472	20.2%
Rutherford	328,279	367,508	11.9%	33,820	42,878	26.8%	11.7%	32.9	$56,219	40,707	12.4%	49,228	15.0%
Williamson	220,746	239,411	8.5%	29,059	36,928	27.1%	15.4%	38.9	$96,555	11,258	5.1%	11,920	5.4%
Counties Total	1,238,363	1,329,584	7.4%	142,906	171,090	19.7%	12.9%	35.3	$67,047	177,424	14.3%	200,620	16.2%
State of TN Total	6,887,572	7,179,512	4.2%	1,133,025	1,312,118	15.8%	18.3%	38.3	$45,219	1,225,988	17.8%	1,412,063	20.5%

Sources: TDOH Population Projections, 2016; U.S. Census QuickFacts; TennCare Bureau.
Service area data is either total, or average, as appropriate.

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

StoneCrest Surgery Center will serve the needs of all of the above groups, as does TriStar StoneCrest Medical Center. The surgery center will contract with Medicare and Medicaid, projecting a case mix of 25.5% Medicare and 12.0% TennCare.

5. Describe the existing and approved but unimplemented services of similar healthcare providers in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. List each provider and its utilization and/or occupancy individually. Inpatient bed projects must provide the following data: admissions or discharges, patient days, average length of stay, and occupancy. Other projects should use the appropriate measures, e.g., cases, procedures, visits, admissions, etc. This does not apply to projects that are solely relocating a service.

The similar or comparable service providers that will be in operation in the primary service area when this facility opens will consist of six multispecialty and single-specialty surgery centers, that perform cases of the specialties projected in this application:

Middle Tennessee Ambulatory Surgery Center	Multispecialty	Murfreesboro
Surgicenter of Murfreesboro Medical Clinic	Multispecialty	Murfreesboro
Williams Surgery Center	Podiatry	Murfreesboro
Mid-State Endoscopy Center	Gastroenterology	Murfreesboro
Physicians Pavilion Surgery Center	Multispecialty	Smyrna
Premier Orthopedic Surgery Center	Orthopedic	Nashville

This group of six facilities excludes some surgery centers that do procedures of types other than what will be offered in this proposed surgery center. For example, eye surgery and pain management.

These facilities are well-utilized. Their 2016 Joint Annual Reports document that as a group, their 16 operating rooms were utilized at 72.8%. Excluding the private practice podiatry facility--which at only 44 annual cases was not a significant surgical resource for area residents--the utilization of these primary service area operating rooms was 77.4%. These group occupancies exceeded the criterion of the State Health Plan recommending that comparable facilities in the applicant's service area should be at least 70% utilized for additional operating rooms to be approved.

The three multispecialty facilities in the project service area are all in fast-growing Rutherford County. Joint Annual Report Data for 2011-2016 indicates that they had a 19.2% increase in O.R. cases in the five years from 2011 to 2016. This far exceeded the overall increase of 12.2% for all area surgery centers.

If the same historic 5-year O.R. case growth rate is projected to 2021 (the second year of operation for StoneCrest Surgery Center) it indicates that these three facilities can share approximately 15,060 O.R. cases. They have 13 O.R.s. That would give them a group average of 1,158 O.R. cases per O.R.--131% above the 884 cases that the State Health Plan defines as optimal 70% utilization of an O.R. StoneCrest Surgery Center, with a different staff of surgeons, will obtain most of its O.R. cases from different referral patterns, and from recruitment of new surgeons.

Following this page are utilization tables presenting historic data in several formats requested by the HSDA staff in prior projects.

ASTC Surgical Room Utilization 2014-2016 StoneCrest Surgery Center Primary Service Area				
	2014	2015	2016	% Change 2014-2016
Multispecialty				
Operating Rooms	13	13	13	0.0%
Cases	11,610	11,862	12,634	8.8%
Cases Per O.R.	893	912	972	8.8%
Procedure Rooms	5	5	5	0.0%
Cases	6,355	6,897	7,664	20.6%
Cases Per PR	1,271	1,379	1,533	20.6%
Single Specialty				
Operating Rooms	3	3	3	0.0%
Cases	2,610	2,221	2,073	-20.6%
Cases Per O.R.	870	740	691	-20.6%
Procedure Rooms	2	2	2	0.0%
Cases	3,209	2,160	2,395	-25.4%
Cases Per PR	1,605	1,080	1,198	-25.4%

Revised Supplemental Table: ASTC Utilization in Primary Service Area in 2016
StoneCrest Surgery Center

Zip Code PSA & Primary County	ASTC	O.R.s	O.R. Cases	Cases Per O.R.	% of 884 Cases/O.R.	Procedure Rooms	Procedure Room Cases	Cases Per Procedure Room	% of 1,867 Procedures /Proc Room
	Multispecialty ASTC's								
37129--Rutherford	Middle Tennessee Ambulatory Surgery Center	6	6214	1036	117.2%	1	934	934	50.0%
37129--Rutherford	Surgicenter of Murfreeesboro Medical Clinic	3	4237	1412	159.8%	3	6036	2012	107.8%
37167--Rutherford	Physicians Pavilion Surgery Center	4	2183	546	61.7%	1	694	694	37.2%
	Subtotal	**13**	**12634**	**972**	**109.9%**	**5**	**7664**	**1533**	**82.1%**
	Single-Specialty ASTC's								
37129--Rutherford	Williams Surgery Center (Podiatry)	1	44	44	5.0%	0	0	0	0.0%
37130--Rutherford	Mid-State Endoscopy Center (GI)	0	0	0	0.0%	1	2395	2395	128.3%
37211--Davidson	Premier Orthopedic Surgery Center (Ortho)	2	2029	1015	114.8%	0	0	0	0.0%
	Subtotal	**3**	**2073**	**691**	**78.2%**	**1**	**2395**	**2395**	**128.3%**
	PSA Grand Total / Average	**16**	**14707**	**919**	**104.1%**	**6**	**10059**	**1677**	**89.8%**

SUPPLEMENTAL #2
July 31, 2017
12:10 pm

Utilization of Existing Surgery Centers in Primary Service Area--2014 to 2016
StoneCrest Surgery Center (Revised 7-31-17)

PSA Zip Code / Primary County	ASTC	2011		2012		2013		2014		2015		2016	
		O.R. Cases	P.R. Cases	O.R. Cases	P.R. Cases	O.R. Cases	P.R. Cases	O.R. Cases	P.R. Cases	O.R. Cases	P.R. Cases	O.R. Cases	P.R. Cases
37129 - Murfreesboro	Middle Tennessee Ambulatory Surgery Center	5,800	464	5,893	597	5,914	638	5,609	666	5,837	873	6,214	934
	Surgicenter of Murfreeesboro Medical Clinic	3,100	4,555	3,174	4,810	3,455	5,066	3,729	5,138	4,034	5,456	4,237	6,036
	Williams Surgery Center (Podiatry)	127	0	65	0	56	0	67	0	56	0	44	0
37130 - Murfreesboro	Mid-State Endoscopy Center	0	134	0	1,043	0	1,632	0	3,209	0	2,160	0	2,395
37167 - Smyrna	Physicians Pavilion Surgery Center	1,698	752	2,031	833	2,489	543	2,272	551	1,991	568	2,183	694
37211 - Nashville	Premier Orthopedic Surgery Center	2,382	0	2,277	0	2,295	0	2,543	0	2,165	0	2,029	0
		13,107	**5,905**	13,440	7,283	14,209	7,879	14,220	9,564	14,083	9,057	**14,707**	**10,059**
			2011										2016
			19,012										24,766

Chge %
130.3%

2021
32,261.5 total cases in 2021

Supplemental 1

52cR2

6. Provide applicable utilization and/or occupancy statistics for your institution for each of the past three years and the projected annual utilization for each of the two years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.

Following this page is a utilization table with the projected utilization of the proposed surgery center and its impact on projected hospital surgery department as cases are migrated from the hospital to the surgery center.

Hospital and HCA management projected hospital cases without the surgery center through Year Two of this project. As the table shows, a conservative annual increase of 3.8% was used, which is lower than the average increase over the past several years. They then reviewed the cases which which they would move to the surgery center, which necessarily was an estimate based on familiarity of the medical staff and eligibility of their cases to be schedule into the new facility.

Actual and Projected Surgical Cases 2013-2021 StoneCrest Medical Center and StoneCrest Ambulatory Surgical Treatment Center									
STONECREST MEDICAL CENTER	**Actual 2013**	**Actual 2014**	**Actual 2015**	**Actual 2016**	**Ann'd 2017**	**Projected 2018**	**Projected 2019**	**Projected 2020**	**Projected 2021**
# Operating Rooms	8	8	8	8	8	8	8	8	8
# Procedure Rooms	3	3	3	3	3	3	3	3	3
Total Rooms	11	11	11	11	11	11	11	11	11
Cases in Operating Rooms	4,680	4,440	4,351	4,086	4,378	4,540	4,708	3,433	3,570
IP	1,032	1,061	998	1,115	1,278	1,316	1,355	1,396	1,438
OP	3,648	3,379	3,353	2,971	3,100	3,224	3,353	2,037	2,132
Cases/O.R.	425	404	396	371	398	413	428	312	325
Cases in Procedure Rooms	1,596	1,762	2,326	2,884	3,448	3,583	3,724	3,370	3,506
IP	229	221	224	254	310	319	329	339	349
OP	1,367	1,541	2,102	2,630	3,138	3,264	3,395	3,031	3,157
Cases/Proc Rm	532	587	775	961	1,149	1,194	1,241	1,123	1,169
Total Hospital Cases	6,276	6,202	6,677	6,970	7,826	8,123	8,432	6,803	7,076
Annual Case Growth Rate		-1.2%	7.7%	4.4%	12.3%	3.8%	3.8%	-19.3%	4.0%
STONECREST SURGERY CENTER								**Projected Yr 1 2020**	**Projected Yr 2 2021**
# Operating Rooms								2	2
# Procedure Rooms								1	1
Total Rooms								3	3
Cases in Operating Rooms								1,450	1,493
Cases/O.R.								725	747
Cases in Procedure Rooms								500	515
Cases/Proc Rm								500	515
Total ASTC Cases								1,950	2,008
Annual Case Growth Rate									3.0%
STONECREST CAMPUS									
Total Campus Outpatient Cases	5,015	4,920	5,455	5,601	6,238	6,488	6,748	7,018	7,297
Annual OP Case Growth Rate		-1.9%	10.9%	2.7%	11.4%	4.0%	4.0%	4.0%	4.0%
Total Campus Cases--IP & OP	6,276	6,202	6,677	6,970	7,826	8,123	8,432	8,753	9,084
Annual IP + OP Case Growth Rate		-1.2%	7.7%	4.4%	12.3%	3.8%	3.8%	3.8%	3.8%

Source: 2015-2016 data from Joint Annual Report. 2017+ data from hospital management and records.

ECONOMIC FEASIBILITY

1. Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.

A. All projects should have a project cost of at least $15,000 (the minimum CON Filing Fee), (See application instructions for Filing Fee.)

B. The cost of any lease, The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.

C. The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.

D. Complete the Square Footage Chart on page 8 and provide the documentation. Please note the Total Construction Cost reported on line 5 of the Project Cost Chart should equal the Total Construction Cost reported on the Square Footage Chart.

This Chart is attached in Section A.12 above as the application form requests.

E. For projects that include new construction, modification, and/or renovation documentation must be provided from a licensed architect or construction professional that support the estimated construction costs. Provide a letter that includes the following:

1) A general description of the project;

2) An estimate of the cost to construct the project; and

3) A description of the status of the site's suitability for the proposed project;

4) Attesting the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the AIA Guidelines for Design and Construction of Hospital and Health Care Facilities in current use by the licensing authority.

See Attachment Section B-Economic Feasibility-1E.

SUPPLEMENTAL #2
July 31, 2017
12:10 pm

PROJECT COST CHART--STONECREST SURGERY CENTER

A.	Construction and equipment acquired by purchase:		
	1. Architectural and Engineering Fees		$ 234,000
	2. Legal, Administrative, Consultant Fees (Excl CON Filing Fee)		50,000
	3. Acquisition of Site		0
	4. Preparation of Site		0
	5. Total Construction Cost	lessee's buildout of shell	3,256,500
	6. Contingency Fund		253,500
	7. Fixed Equipment (Not included in Construction Contract)		2,750,000
	8. Moveable Equipment (List all equipment over $50,000 as separate attachment)		0
	9. Other (Specify) _____		0
B.	Acquisition by gift, donation, or lease:	(leased building and land)	
	1. Facility (inclusive of building and land)		
	2. Building only	lessor's cost to construct shell*	2,925,000
	3. Land only	lessor's land value*	871,200
	4. Equipment (Specify) _____		0
	5. Other (Specify) _____		0
C.	Financing Costs and Fees:		
	1. Interim Financing		156,000
	2. Underwriting Costs		0
	3. Reserve for One Year's Debt Service		0
	4. Other (Specify) _____		0
D.	Estimated Project Cost (A+B+C)		10,496,200
E.	CON Filing Fee		60,353
F.	Total Estimated Project Cost (D+E)	TOTAL $	10,556,553

*land and shell cost $3,796,200 > lease outlay of $3,442,603 so higher land + shell $ must be used in Section B per CON rules

2. Identify the funding sources for this project.

Check the applicable item(s) below and briefly summarize how the project will be financed. (Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)

_____A. Commercial Loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;

_____B. Tax-Exempt Bonds--copy of preliminary resolution or a letter from the issuing authority, stating favorable contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;

_____C. General Obligation Bonds--Copy of resolution from issuing authority or minutes from the appropriate meeting;

_____D. Grants--Notification of Intent form for grant application or notice of grant award;

__X___E. Cash Reserves--Appropriate documentation from Chief Financial Officer; or

__X__F. Other--Identify and document funding from all sources.

The $10,556,553 project cost includes the market value of the project site on the StoneCrest Medical Center campus. That land is already owned by HCA Health Services of Tennessee, Inc., an HCA subsidiary. Excluding the land value, the actual capital cost of the project will require funding of $9,685,353 ($10,556,553 - land valued at $871,200).

HCA Healthcare Inc., which is the ultimate parent of HCA StoneCrest Medical Center and of the new StoneCrest Surgery Center, LLC, will fund a minimum of $8,029,067 of the actual project cost. The project is intended to be syndicated to StoneCrest physicians, who will contribute up to $1,656,286 to the project. HCA Healthcare, Inc. will provide any portion of this projected syndication contribution that is not raised by the syndication offering.

Structurally, the funding is planned as follows:

1. HCA Healthcare, Inc. will transfer $2,295,000 to its wholly-owned affiliatesfor the construction of the shell building on the StoneCrest campus.

2. HCA Healthcare, Inc. will transfer to its wholly-owned affiliates $3,380,177, to fund 50% of the CON process, architectural planning of the build-out of the shell building, and equipment and licensure of the finished surgery center--i.e., 50% of all cost items set forth on the Project Cost Chart other than Section B items.

3. Of the remaining actual costs of $3,380,337, HCA Healthcare, Inc. will transfer to its wholly-owned affiliates the funds for 51%, or $1,723,890.

4. A syndication will offer physicians up to 49% of the facility ownership, which is expected to generate $1,723,890. That will complete the funding of $9,685,353 required to implement the project. (Again, HCA Healthcare, Inc. will contribute additional funds to cover any shortfall in the physician syndication.)

Total HCA Funding:	$2,925,000
	$3,380,177
	$1,723,890
HCA subtotal:	$8,029,067
Physician Investment:	$1,656,286
Grand Total:	**$9,685,353**

A letter from TriStar Health System documenting HCA Healthcare, Inc.'s intention and ability to fund the project up to 100% of the required cost, if necessary, is provided in the Attachments to the application.

3. Complete Historical Data Charts on the following pages--Do not modify the Charts or submit Chart substitutions!

Historical Data Chart represents revenue and expense information for the last three (3) years for which complete data is available. Provide a Chart for the total facility and Chart just for the services being presented in the proposed project, if applicable. Only complete one chart if it suffices.

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

Not applicable. An Historical Data Chart is not required because the applicant is a new entity proposing to establish a new facility that as yet has no operating history.

3. **Complete Projected Data Charts on the following pages – *Do not modify the Charts provided or submit Chart substitutions!***

The Projected Data Chart requests information for the two years following the completion of the proposed services that apply to the project. Please complete two Projected Data Charts. One Projected Data Chart should reflect revenue and expense projections for the *Proposal Only* (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility). The second Chart should reflect information for the total facility. Only complete one chart if it suffices.

Note that "Management Fees to Affiliates" should include management fees paid by agreement to the parent company, another subsidiary of the parent company, or a third party with common ownership as the applicant entity. "Management Fees to Non-Affiliates" should include any management fees paid by agreement to third party entities not having common ownership with the applicant.

Following this page are Projected Data Charts for the proposed StoneCrest Surgery Center and for the Surgery Department of TriStar StoneCrest Medical Center.

X TOTAL FACILITY
O PROJECT ONLY

PROJECTED DATA CHART -- STONECREST AMBULATORY SURGICAL CENTER

Give information for the last three (3) years for which complete data are available for the facility or agency.
The fiscal year begins in January.

			Year 2020 (Year One)	Year 2021 (Year Two)
A.	Utilization Data (Specify unit or measure)	Cases	1,950	2,008
B.	Revenue from Services to Patients			
	1. Inpatient Services		$	$
	2. Outpatient Services		26,012,110	27,324,259
	3. Emergency Services			
	4. Other Operating Revenue			
	(Specify) See notes page			
		Gross Operating Revenue	$ 26,012,110	$ 27,324,259
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments		$ 22,334,217	$ 23,460,840
	2. Provision for Charity Care		26,012	27,324
	3. Provisions for Bad Debt		73,038	76,722
		Total Deductions	$ 22,433,267	$ 23,564,886
NET OPERATING REVENUE			$ 3,578,842	$ 3,759,373
D.	Operating Expenses			
	1. Salaries and Wages			
	a. Clinical		$ 567,428	$ 584,629
	b. Non-Clinical		245,308	251,446
	2. Physicians Salaries and Wages			
	3. Supplies		638,755	677,462
	4. Rent			
	c. Paid to Affiliates		300,300	309,309
	d. Paid to Non-Affiliates			
	5. Management Fees			
	a. Paid to Affiliates		178,942	187,969
	b. Paid to Non-Affiliates			
	6. Other Operating Expenses	See notes page	561,718	573,431
		Total Operating Expenses	$ 2,492,451	$ 2,584,246
E.	**Earnings Before Interest, Taxes, and Depreciation**		$ 1,086,391	$ 1,175,127
F.	Non-Operating Expenses			
	1. Taxes		$ 31,412	$ 67,239
	2. Depreciation		740,000	757,188
	3. Interest		265,847	245,532
	4. Other Non-Operating Expenses			
		Total Non-Operating Expenses	$ 1,037,259	$ 1,069,959
NET INCOME (LOSS)			$ 49,132	$ 105,169

Chart Continues Onto Next Page

	Year 2020	Year 2021
NET INCOME (LOSS)	$ 49,132	$ 105,169
G. Other Deductions		
1. Annual Principal Debt Repayment	$ 281,023	$ 301,339
2. Annual Capital Expenditure	100,000	175,000
Total Other Deductions	$ 381,023	$ 476,339
NET BALANCE	$ (331,892)	$ (371,170)
DEPRECIATION	$ 740,000	$ 757,188
FREE CASH FLOW (Net Balance + Depreciation)	$ 408,108	$ 386,017

X **TOTAL FACILITY**
O **PROJECT ONLY**

PROJECTED DATA CHART -- OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2020	Year 2021
1. Professional Fees	$ 24,000	$ 24,000
2. Contract Services	102,601	103,575
3. Repairs/Maintenance	87,645	92,066
4. Property Taxes	109,795	110,335
5. Insurance	17,550	18,525
6. Utilities	169,000	173,225
7. Equipment Leases	0	0
8. Other	51,126	51,705
9.		
10.		
11.		
12.		
13.		
14		
15.		
Total Other Expenses	$ 561,718	$ 573,431

O TOTAL FACILITY
X PROJECT ONLY

PROJECTED DATA CHART --STONECREST MEDICAL CENTER SURGICAL DEPARTMENT

Give information for the last three (3) years for which complete data are available for the facility or agency.
The fiscal year begins in January.

			Year 2020 (Year One)	Year 2021 (Year Two)
A.	Utilization Data (Specify unit or measure)	Cases	6,803	7,076
B.	Revenue from Services to Patients			
	1. Inpatient Services		$ 146,139,251	$ 162,560,755
	2. Outpatient Services		107,388,269	121,036,835
	3. Emergency Services			
	4. Other Operating Revenue			
	(Specify) See notes page			
		Gross Operating Revenue	$ 253,527,520	$ 283,597,590
C.	Deductions from Gross Operating Revenue			
	1. Contractual Adjustments		$ 190,809,749	$ 216,866,201
	2. Provision for Charity Care		177,469	198,518
	3. Provisions for Bad Debt		8,112,881	9,075,123
		Total Deductions	$ 199,100,099	$ 226,139,842
NET OPERATING REVENUE			$ 54,427,421	$ 57,457,748
D.	Operating Expenses			
	1. Salaries and Wages			
	a. Clinical		$ 6,975,284	$ 7,416,339
	b. Non-Clinical		5,024,024	5,341,698
	2. Physicians Salaries and Wages		0	0
	3. Supplies		12,618,072	13,415,926
	4. Rent			
	c. Paid to Affiliates		0	0
	d. Paid to Non-Affiliates		182,016	193,525
	5. Management Fees			
	a. Paid to Affiliates		3,347,215	3,493,074
	b. Paid to Non-Affiliates		0	0
	6. Other Operating Expenses	See notes page	8,707,934	9,258,545
		Total Operating Expenses	$ 36,854,545	$ 39,119,107
E.	**Earnings Before Interest, Taxes, and Depreciation**		$ 17,572,876	$ 18,338,641
F.	Non-Operating Expenses			
	1. Taxes		$ 6,260,295	$ 6,500,067
	2. Depreciation		1,312,980	1,452,370
	3. Interest		207,858	219,431
	4. Other Non-Operating Expenses		0	0
		Total Non-Operating Expenses	$ 7,781,133	$ 8,171,869
NET INCOME (LOSS)			$ 9,791,743	$ 10,166,772

Chart Continues Onto Next Page

	Year 2020	Year 2021
NET INCOME (LOSS)	$ 9,791,743	$ 10,166,772
G. Other Deductions		
1. Annual Principal Debt Repayment	$	$
2. Annual Capital Expenditure		
Total Other Deductions	$ 0	$ 0
NET BALANCE	$ 9,791,743	$ 10,166,772
DEPRECIATION	$ 1,312,980	$ 1,452,370
FREE CASH FLOW (Net Balance + Depreciation)	$ 11,104,723	$ 11,619,142

0 TOTAL FACILITY
X PROJECT ONLY

PROJECTED DATA CHART -- OTHER EXPENSES

OTHER EXPENSES CATEGORIES	Year 2020	Year 2021
1. Professional Fees	$ 5,043,827	5,362,754
2. Contract Services	1,141,622	$ 1,213,808
3. Repairs/Maintenance	739,754	786,529
4. Insurance	105,364	112,026
5. Utilities	180,469	191,880
6. Other	1,496,898	1,591,548
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14		
15.		
Total Other Expenses	$ 8,707,934	$ 9,258,545

5.A. Please identify the project's average gross charge, average deduction from operating revenue, and average net charge using information from the Projected Data Chart for Year 1 and Year 2 of the proposed project. Please complete the following table.

	Project Previous Year	Project Current Year	Project Year One	Project Year Two	% Change (Current Yr to Yr2)
Gross Charge (Gross Operating Revenue/Utilization Data	NA	NA	$13,340	$13,607	+2.0%
Deduction from Revenue (Total Deductions/Utilization Data)	NA	NA	$11,504	$11,735	+2.0%
Average Net Charge (Net Operating Revenue/Utilization Data)	NA	NA	$1,835	$1,872	+2.6%

B. Provide the proposed charges for the project and discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the project and the impact on existing patient charges.

There will be no adjustment to current charges because this is a proposal to establish a new facility.

The projected charges for the most frequently performed procedures are provided on the following page.

StoneCrest Surgery Center Charge Data for Most Frequent Ambulatory Surgical Procedures All Specialties					
			Average Gross Charge		
CPT	Descriptor	2017 Medicare Allowable	Current	ASTC Year 1	ASTC Year 2
45378	DIAGNOSTIC COLONOSCOPY	361.01	5,803	5,919	6,038
42820	REMOVE TONSILS AND ADENOIDS	2,039.51	7,261	7,406	7,554
29881	KNEE ARTHROSCOPY/SURGERY	1,219.54	21,367	21,795	22,231
45380	COLONOSCOPY AND BIOPSY	474.51	9,469	9,658	9,851
29827	ARTHROSCOP ROTATOR CUFF REPR	2,651.09	48,847	49,824	50,821
64721	CARPAL TUNNEL SURGERY	789.34	11,386	11,614	11,846
29848	WRIST ENDOSCOPY/SURGERY	695.88	14,218	14,503	14,793
58670	LAPAROSCOPY TUBAL CAUTERY	2,040.04	9,657	9,850	10,047
29880	KNEE ARTHROSCOPY/SURGERY	1,219.54	20,750	21,165	21,588
30420	RECONSTRUCTION OF NOSE	2,039.51	5,006	5,106	5,208
58558	HYSTEROSCOPY BIOPSY	1,066.87	11,880	12,117	12,360
47562	LAPAROSCOPIC CHOLECYSTECTOMY	2,040.04	18,635	19,008	19,388
46260	REMOVE IN/EX HEM GROUPS 2+	1,114.69	7,588	7,740	7,895
45385	COLONOSCOPY W/LESION REMOVAL	474.51	11,861	12,098	12,340
26055	INCISE FINGER TENDON SHEATH	695.88	9,684	9,878	10,075
29888	KNEE ARTHROSCOPY/SURGERY	2,651.09	38,568	39,340	40,126
49505	PRP I/HERN INIT REDUC >5 YR	1,454.83	7,920	8,079	8,240
43239	EGD BIOPSY SINGLE/MULTIPLE	378.37	9,624	9,817	10,013
20680	REMOVAL OF SUPPORT IMPLANT	1,032.03	8,863	9,041	9,221
28296	CORRECTION OF BUNION	1,219.54	15,274	15,580	15,892

C. Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).

The table on the preceding page shows current Medicare allowable fee schedules for the procedures to be most frequently performed in the StoneCrest Surgery Center.

The table below compares gross and net charges for total cases in similar facilities in the declared service area, as reported in their Joint Annual Reports for 2016, the most recent source of such data. It compares those averages to this project's projected gross and net charges for total cases in CY2020, four years later than the data available for the existing facilities.

Gross revenue is equivalent to the facility's charge schedule, before adjustments. Net revenue is gross revenue minus contractual adjustments, bad debt, and charity, and other deductions (no expenses deducted at that point). Net revenue per case is what payers (patients and their insurors) actually pay the facility.

In the existing facilities, the lowest net revenue per case data are from two facilities that performed 24%-59% of their cases in their procedure rooms. The highest net revenue per case was at the facility that performed only 8% of its cases in its procedure rooms. Procedure room cases are much less costly to perform. So the facility with the lowest percentage of procedure room cases would be expected to have a higher average net revenue.

Without more JAR information on case revenues by types of surgical room, it is not very meaningful to compare charges among these facilities.

Comparison To Existing Service Area Facilities That Provide Similar Services

ASTC	JAR Year	Cases	Gross Revenue	Net Revenue	Gross Rev. Per Case	Net Rev. Per Case
Middle Tennessee Ambulatory Surgery Center	2016	7,148	$76,181,248	$15,324,792	$10,658	*$2,144*
Surgicenter of Murfreeesboro Medical Clinic	2016	10,273	$15,278,321	$8,181,285	$1,487	*$796*
Physicians Pavilion Surgery Center	2016	2,877	$9,968,748	$1,581,230	$3,465	*$550*
This Project: StoneCrest Surgery Center	CY 2020	1,950	$26,012,110	$3,578,842	$13,340	*$1,835*

6.A. Discuss how projected utilization rates will be sufficient to support the financial performance. Indicate when the project's financial breakeven is expected and demonstrate the availability of sufficient cash flow until financial viability is achieved.

The applicant's Projected Data Chart provides income and cash flow data that demonstrate that the proposed surgery center will have a positive cash flow and operating margin in its first two years of operation.

Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For all projects, provide financial information for the corporation, partnership, or principal parties that will be a source of funding for the project.

Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility. NOTE: Publicly held entities only need to reference their SEC filings.

See Attachment Section B-Economic Feasibility-6A for the financial information about the corporate parent that will provide project funding, This is a proposed facility so there are no financial statements for StoneCrest Surgery Center itself.

B. Net Operating Margin Ratio – Demonstrates how much revenue is left over after all the variable or operating costs have been paid. The formula for this ratio is: (Earnings before interest, Taxes, and Depreciation/Net Operating Revenue).

Utilizing information from the Historical and Projected Data Charts please report the net operating margin ratio trends in the following table:

	2nd Yr Previous to Current Yr	1st Yr Previous to Current Yr	Current Yr	Projected Yr 1	Projected Yr 2
Net Operating Margin Ratio	NA	NA	NA	.304	.313

C. Capitalization Ratio (Long-term debt to capitalization) – Measures the proportion of debt financing in a business's permanent (Long-term) financing mix. This ratio best measures a business's true capital structure because it is not affected by short-term financing decisions. The formula for this ratio is: (Long-term debt/(Long-term debt + Total Equity (Net assets)) x 100).

For the entity (applicant and/or parent company) that is funding the proposed project please provide the capitalization ratio using the most recent year available from the funding entity's audited balance sheet, if applicable. The Capitalization Ratios are not expected from outside the company lenders that provide funding.

7. Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid and medically indigent patients will be served by the project. Additionally, report the estimated gross operating revenue dollar amount and percentage of projected gross operating revenue anticipated by payor classification for the first year of the project by completing the table below.

Applicant's Projected Payor Mix, Year 1		
Payor Source	**Projected Gross Operating Revenue**	**As a Percent of Total Revenue**
Medicare/Medicare Managed Care	$6,633,088	25.5%
TennCare/Medicaid	$3,121,453	12.0%
Commercial/Other Managed Care	$13,240,164	50.9%
Self-Pay	$1,014,472	3.9%
Charity Care	$26,012	0.1%
Other	$2,002,932	7.7%
Total	$26,012,110	100.0%

8. Provide the projected staffing for the project in Year 1 and compare to the current staffing for the most recent 12-month period, as appropriate. This can be reported using full-time equivalent (FTE) positions for these positions. Additionally, please identify projected salary amounts by position classifications and compare the clinical staff salaries to prevailing wage patterns in the proposed service area as published by the Department of Labor & Workforce Development and/or other documented sources.

See the staffing table on the following page.

Supplemental Table: Current and Projected Staffing StoneCrest Surgery Center				
Position Classification	**Existing FTEs (NA)**	**Projected FTEs (Yr 1)**	**Average Annual Salary (Contractual Rate)**	**Estimated Areawide Average Salary**
A. Direct Patient Care Positions				
OR Manager		1.00	$70,000	$60,000 $80,000
RN OR		1.00	$66,560	$55,000-$70,000
Tech OR		2.25	$45,760	$40,000-$50,000
RN PACU/Pre-op		3.00	$58,240	$55,000-$70,000
Materials Manager		1.00	$41,600	$40,000-$50,000
Total Direct Patient Care Positions	0.00	8.25		
B. Non-Patient Care Positions				
Administrator		1.00	$110,000	$90,000-$120,000
Business Office Manager		1.00	$60,000	$55,000-$70,000
Receptionist		1.00	$27,040	$25,000-$30,000
Total Non-Patient Care Positions	0.00	3.00		
Total Employees (A + B)	0.00	11.25		
C. Contractual Staff	0.00	0.00		
Total Staff (A+B+C)	0.00	11.25		

Source: Applicant's management.

9. Describe all alternatives to this project that were considered and discuss the advantages and disadvantages of each alternative, including but not limited to:

A. Discuss the availability of less costly, more effective and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, justify why not, including reasons as to why they were rejected.

TriStar StoneCrest Medical Center has been discussing a joint-ventured surgery center option with its medical staff since 2014. Interest is now strong enough, and case growth is strong enough, to make such a project appropriate.

There is not an acceptable alternative to proceeding with a plan to develop a hospital-affiliated surgery center. To not proceed is unacceptable for the reasons set forth in the applicant's response to State Health Plan CON review criteria and other sections of the application preceding those responses. Cost of care factors are driving Medicare and employers and patients to aggressively seek surgical settings that can reduce their payments to hospitals for outpatient surgery cases. Insurors and other companies are making available "transparency" software and technology to allow consumers to shop for high-quality but lower-cost facilities to avoid having to use more expensive hospital or hospital outpatient department (HOPD) surgical suites.

More than cost factors make this a necessity for the applicant. Surgeons want closer collaboration with hospitals about the operation of surgical suites. Patients want the convenience and efficiency of a surgery center. Patients also are interested in avoiding hospital facilities where there are issues of infection risks from medication-resistant new viruses.

B. Document that consideration has been given to alternatives to new construction, e.g., modernization or sharing arrangements.

Before proposing to develop additional operating room capacity in the primary service area, StoneCrest has pursued ASTC acquisition opportunities in its service area--but without success. Building a new freestanding ambulatory surgery center is now the hospital's best remaining option.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1. List all existing health care providers (i.e., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, that may directly or indirectly apply to the project, such as transfer agreements or contractual agreements for health services.

The applicant is already part of an acute care organization that includes StoneCrest Medical Center and its parent company, as well as an experienced surgery center development and management company.

With these linkages in place the applicant has rapid access to a variety of resources for facility development and operation, purchasing, physician staff recruitment, financial management, and other required activities.

Being co-located on the campus with its affiliated hospital, the facility will have an emergency transfer agreement with TriStar StoneCrest Medical Center.

A list of TriStar's Tennessee acute care facilities is provided in AttachmentA-4A.

2. Describe the effects of competition and/or duplication of the proposal on the health care system, including the impact to consumers and existing providers in the service area. Discuss any instances of competition or duplication arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

A. Positive Effects

The project will provide cost savings for service area patients, their employers, and their insurors. It will give patients and surgeons a more efficient facility that will have simpler paperwork and faster case times for these types of procedures than is feasible in a hospital environment. It will make it unnecessary for thousands of surgical outpatients a year to enter an acute care hospital building that is more complex and has perceived higher risks of infection.

B. Negative Effects

The project will add a multispecialty ASTC to the service area. There are three such facilities existing now within Rutherford County. Their average utilization already exceeds 70%, which is the State Plan's "optimal" threshold for adding O.R. capacity in an ASTC. The increase in reported O.R. cases for these facilities as a group, over the past five years (2011-2016), has been 19.2%.

If the same historic 5-year O.R. case growth rate is projected to 2021 (the second year of operation for StoneCrest Surgery Center) it indicates that these three facilities can share approximately 15,060 O.R. cases. They have 13 O.R.s. That would give them a group average of 1,158 O.R. cases per O.R.--131% above the 884 cases that the State Health Plan defines as optimal 70% utilization of an O.R. StoneCrest Surgery Center, with a different staff of surgeons, will not significantly adversely impact utilization of those facilities as a group, because those facilities perform most of their O.R. cases for different surgeons than those using the StoneCrest campus.

The only hospital that will be significantly impacted by this project is TriStar StoneCrest Medical Center, which is sponsoring this project to provide the community benefits stated above. StoneCrest will have reduced outpatient surgery cases because the surgery center will derive most of its cases from StoneCrest Medical Center itself.

However, although this will be a statistical impact, it will not place a significant financial burden on the hospital. Surgery departments are among the few hospital departments that generate positive margins strong enough to carry other departments and services that do not have positive margins. As this application's Projected Data Chart for the Surgery Department indicates, that Department will retain a very strong positive cash flow and operating margin even without the loss of cases to the new StoneCrest Surgery Center.

3.A Discuss the availability of an accessibility to human resources required by the proposal, including clinical leadership and adequate professional staff, as per the State of Tennessee licensing requirements and/or requirements of accrediting agencies such as the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities.

The project can be partially staffed with personnel currently working in the hospital's Surgery Department, which will need fewer employees with the proposed reduction in outpatient caseloads. The applicant is confident that any staff required for the facility can be readily recruited both from that source and from Middle Tennessee.

The medical staff of the facility will be drawn from the existing medical staff of the hospital.

The operators of this facility are experienced in surgery center management in Tennessee. All staff of the facility will comply with all applicable requirements of Medicare, of Licensure, and of the AAAHC, by whom it will be accredited.

B. Verify that the applicant has reviewed and understands all licensing and/or certification as required by the State of Tennessee and/or accrediting agencies such as the Joint Commission for medical/clinical staff. These include, without limitation, regulations concerning clinical leadership, physician supervision, quality assurance policies and programs, utilization review policies and programs, record keeping, clinical staffing requirements, and staff education.

The applicant so verifies.

C. Discuss the applicant's participation in the training of students in the areas of medicine, nursing, social work, etc. (e.g., internships, residencies, etc.).

Please see the following page.

TriStar StoneCrest Health Professional Training Agreements

Colleges

American Sentinel University - BSN, MSN & DNP
Austin Peay - Radiologic Technology/Lab
Belmont University - Nursing
Belmont University - PT/OT
Belmont University - Pharmacy
Chamberlain College - Nursing
Cumberland University - Nursing
Fortis - Nursing
Fortis - Surgical Tech
Lipscomb - Pharmacy
Loyola University - Nurse Practitioner
Meridian-Institute - Surgical First Assist
Miller-Motte - Polysomnography & RT
Motlow - Nursing
MTSU - Nursing
Nashville General – Rad Tech
Nashville State - Surgical Tech & Central Processing
Priority Nutrition Care LLT – Dietary
St. Ambrose University - PT, OT & Speech
TN Tech Murfreesboro - Pharmacy Tech & Surgical Tech
TN Tech Nashville - Nursing
University of Colorado - Pharmacy
Volunteer State - Diagnostic Medical Sonography, HIM, PT Assistant, & RT, EMS, Rad Tech, Lab Tech & Phlebotomy

Additional Division Level Agreements:

Western Governors University - Nursing
Bethel – Nursing
TSU – Nursing
South College – Nursing
Chamberlain – Nursing

Total College Students in 2016: 230

High School Affiliations:

Blackman – 15 students in 2016
Smyrna – 10 students in 2016
Stewarts Creek – 31 students in 2016

4. Identify the type of licensure and certification requirements applicable and verify that the applicant has reviewed and understands them. Discuss any additional requirements, if applicable. Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.

Licensure Sought: Ambulatory Surgery Treatment Center; to be requested from Board for Licensing Health Care Facilities, Tennessee Department of Health.

Certification Type : Multispecialty Ambulatory Surgery Treatment Center

Accreditation Sought: AAAHC

A. If an existing institution, describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility and accreditation designation.

Not applicable to a new facility.

B. For existing providers, please provide a copy of the most recent statement of deficiencies/plan of correction and document that all deficiencies/findings have been corrected, by providing a letter from the appropriate agency.

Not applicable to a new facility.

C. Document and explain inspections within the past three survey cycles which have resulted in any of the following state, federal, or accrediting body actions: suspension of admissions, civil monetary penalties, notice of 23- ore 90-day termination proceedings from Medicare or Medicaid/TennCare, revocation/denial of accreditation, or other similar actions.
(1) Discuss what measures the applicant has or will put in place to avoid similar findings in the future.

Not applicable to a proposed new facility.

5. Respond to all of the following and for such occurrences, identify, explain, and provide documentation:

The applicant has made a good faith effort to respond to this question regarding the entities identified in its organization chart. To the best of its knowledge, information and belief. Due to the breadth of the question and a lack of definition of key terms, the applicant cannot represent these responses are totally comprehensive, but no responsive information is being intentionally withheld. Because there is no central repository for the information sought, and because of the length of time some of the entities have been in existence, the applicant's responses are limited to the past 5 years as a reasonable look-back period.

A. Has any of the following:
(1) Any person(s) or entity with more than 5% ownership (direct or indirect) in the applicant (to include any entity in the chain of ownership for applicant);

No

(2) Any entity in which any person(s) or entity with more than 5% ownership (direct of indirect) in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than 5%; and/or

No

(3) Any physician or other provider of health care, or administrator employed by any entity in which any person(s) or entity with more than 5% ownership in the applicant (to include any entity in the chain of ownership for applicant) has an ownership interest of more than5%...

B. Been subjected to any of the following:
(1) Final Order or Judgment in a State licensure action;

We assume for the purpose of this question that "state licensure action" refers to facility licensure. StoneCrest Medical Center and/or its owner has not been subjected to Final Order or Judgment in a state licensure action. The other entities in the chain of ownership do not hold a hospital license.

(2) Criminal fines in cases involving a Federal or State health care offense;

No

(3) Civil monetary penalties in cases involving a Federal or State health care offense;

No

(4) Administrative monetary penalties in cases involving a Federal or State health care offense;

No

(5) Agreement to pay civil or monetary penalties to the Federal government or any State in cases involving claims related to the provision of health care items and services; and/or

Please see the response to (3) and (4) above.

(6) Suspension or termination of participation in Medicare or Medicaid/TennCare programs;

No

(7) Is presently subject of/to an investigation, regulatory action, or party in any civil or criminal action of which you are aware;

No

(8) Is presently subject to a corporate integrity agreement.

No

HCA Ambulatory Surgery Division

July 24, 2017

Melanie M. Hill
Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, TN 37243

RE: StoneCrest Surgery Center

Dear Ms. Hill:

This letter is written in relation to the CON application on behalf of StoneCrest Surgery Center. I am Senior Vice President for the HCA Ambulatory Surgery Division, which operates and manages the HCA-affiliate ambulatory surgery centers. As such, I attest to the following:

(a) Applicant commits to maintaining an actual payor mix that is comparable to the payor mix projected in its CON application, including as it relates to Medicare, TennCare/Medicaid, Charity Care, and the Medically Indigent;

(b) The applicant commits to maintaining staffing comparable to the staffing chart presented in its CON application;

(c) The applicant will obtain and maintain all applicable state licenses in good standing;

(d) The applicant will obtain and maintain TennCare and Medicare certification(s), if participation in such programs was indicated in the application;

(e) The applicant is a proposed new healthcare facility, and thus has no compliance history. However, the proposed surgery center will maintain compliance with all applicable laws and regulations.

(f) The applicant is a proposed new healthcare facility, and thus has not been de-certified by any certifying agency.

(g) The applicant will participate, within 2 years of implementation of the project, in self-assessment and external peer assessment processes used by health care organizations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve.

HCA Ambulatory Surgery Division

(i) This may include accreditation by any organization approved by Centers for Medicare and Medicaid Services (CMS) and other nationally recognized programs. The Joint Commission or its successor, for example, would be acceptable if applicable. Other acceptable accrediting organizations may include, but are not limited to, the following:

(ii) Accreditation Association for Ambulatory Health Care, and where applicable, American Association for Accreditation of Ambulatory Surgical Facilities, for Ambulatory Surgical Treatment Center projects.

(h) The applicant has estimated the number of physicians by specialty expected to utilize the facility, developed criteria to be used by the facility in extending surgical and anesthesia privileges to medical personnel, and documented the availability of appropriate and qualified staff that will provide ancillary support services, whether on- or off-site.

Please let me know if you have additional questions.

Sincerely,

Tim Evans
Senior Vice President
HCA, Ambulatory Surgery Division

6. Outstanding Projects:

a. Complete the following chart by entering information for each applicable outstanding CON by applicant or share common ownership; and
b. Provide a brief description of the current progress, and status of each applicable outstanding CON.

Outstanding Projects					
			Annual Progress Report*		
CON Number	Project Name	Date Approved	Due Date	Date Filed	Expiration Date
CN					
Status:					
CN					
Status:					
CN					
Status:					
CN					
Status:					
CN 000-000	OR Addition	4-15-16	4-15-17		4-15-18
Status: Construction began on April 1; opening date unchanged					

* Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

7. Equipment Registry -- For the applicant and all entities in common ownership with the applicant.

a. Do you own, lease, operate, and/or contract with a mobile vendor for a Computed Tomography Scanner (CT), Linear Accelerator, Magnetic Resonance Imaging (MRI), and/or Positron Emission Tomographer (PET)?

No.

b. If yes, have you submitted their registration to HSDA? If you have, what was the date of the submission?

Not applicable.

c. If yes, have you submitted their utilization to HSDA? If you have, what was the date of the submission?

Not applicable.

Facility	Date of HSDA Registration	Date of Last Utilization Submittal

QUALITY MEASURES

Please verify that the applicant will report annually using forms prescribed by the Agency, concerning continued need and appropriate quality measures as determined by the Agency pertaining to the Certificate of Need, if approved.

The applicant so verifies.

SECTION C: STATE HEALTH PLAN QUESTIONS

T.C.A. §68-11-1625 requires the Tennessee Department of Health's Division of Health Planning to develop and annually update the State Health Plan (found at http://www.tn.gov/health/topic/health-planning). The State Health Plan guides the State in the development of health care programs and policies and in the allocation of health care resources in the State, including the Certificate of Need program. The 5 Principles for Achieving Better Health are from the State Health Plan's framework and inform the Certificate of Need program and its standards and criteria.

Discuss how the proposed project will relate to the 5 Principles for Achieving Better Health found in the State Health Plan.

1. The purpose of the State Health Plan is to improve the health of the people of Tennessee.

The project will expand the capacity of service area ambulatory surgical facilities, enabling StoneCrest to more efficiently meet rising demand for this type of care from patients, insurors, and physicians.

2. People in Tennessee should have access to health care and the conditions to achieve optimal health.

The addition of an efficient ambulatory surgery center on the StoneCrest campus increases access to surgical services in the community.

3. Health resources in Tennessee, including health care, should be developed to address the health of people in Tennessee while encouraging economic efficiencies.

The project provides improved efficiency for patients and physicians using the StoneCrest campus for their surgical care.

4. People in Tennessee should have confidence that the quality of health care is continually monitored and standards are adhered to by providers.

The proposed facility will be licensed, certified, AAAHC-accredited, and operated with this company's robust quality control programs.

5. The state should support the development, recruitment, and retention of a sufficient and quality health workforce.

The addition of a new facility will help attract and retain new health care professionals.

PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper that includes a copy of the publication as proof of the publication of the letter of intent.

NOTIFICATION REQUIREMENTS

(Applies only to Nonresidential Substitution-Based Treatment Centers for Opiate Addiction)

Note that T.C.A. §68-11-1607(c)(3) states that "…Within ten (10) days of filing an application for a nonresidential substitution-based treatment center for opiate addiction with the agency, the applicant shall send a notice to the county mayor of the county in which the facility is proposed to be located, the member(s) of the House of Representatives and the Senator of the General Assembly representing the district in which the facility is proposed to be located, and to the mayor of the municipality, if the facility is proposed to be located within the corporate boundaries of a municipality, by certified mail, return receipt requested, informing such officials that an application for a nonresidential substitution based treatment center for opiate addiction has been filed with the agency by the applicant."

Failure to provide the notifications described above within the required statutory timeframe will result in the voiding of the CON application.

Please provide documentation of these notifications.

Not applicable.

DEVELOPMENT SCHEDULE

T.C.A. §68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

The application will be heard in October 2017. If granted then, the normal 2-year implementation period would expire before the end of 2019. The development schedule on the following page indicates that fully 2 years will be needed to develop such a project. The applicant intends to do so, and has both the resources and expertise to accomplish it. However, to provide a margin of safety from unforeseen circumstances, and to provide ample time to accomplish the intended syndication, the applicant requests that the implementation period be granted for 30 months, or 2.5 years.

PROJECT COMPLETION FORECAST CHART

Assuming the Certificate of Need (CON) approval becomes the final HSDA action on the date listed in Item 1. below, indicate the number of days from the HSDA decision date to each phase of the completion forecast.

PHASE	DAYS REQUIRED	Anticipated Date (MONTH /YEAR)
1. Initial HSDA Decision Date	0	10/2017
1. Architectural & engineering contract signed	15	11/2017
2. Construction documents approved by TDH	195	5/18
3. Construction contract signed	225	6/18
4. Building permit secured	240	7/18
5. Site preparation completed	270	7/18
6. Building construction commenced	280	8/18
7. Construction 40% complete	400	12/18
8. Construction 80% complete	520	5/18
9. Construction 100% complete	610	8/19
10. * Issuance of license	625	9/19
11. *Initiation of service	630	10/19
12. Final architectural certification of payment	720	1/20
13. Final Project Report Form (HF0055)	780	3/20

*** For projects that DO NOT involve construction or renovation: please complete items 11-12 only.**

Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

JOHN WELLBORN, being first duly sworn, says that he is the lawful agent of the applicant named in this application, that this project will be completed in accordance with the application to the best of the agent's knowledge, that the agent has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of the agent's knowledge.

SIGNATURE/TITLE
CONSULTANT

Sworn to and subscribed before me this 25th day of July (Month), 2017 (Year) a Notary

Public in and for the County/State of DAVIDSON

JAN M. DANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 2, 2018

NOTARY PUBLIC

My commission expires July 2, (Month/Day), 2018 (Year).

INDEX OF ATTACHMENTS

Section A

Section B

Other Attachments

A-3A(1)

Trends in Surgical Sites of Service

Commercial Insurance Cost Savings in Ambulatory Surgery Centers

Healthcare Bluebook™

ASCA
Ambulatory Surgery Center Association

HealthSmart®

Executive Summary

A review of commercial medical-claims data found that U.S. healthcare costs are reduced by more than $38 billion per year due to the availability of ambulatory surgery centers (ASCs) as an appropriate setting for outpatient procedures. More than $5 billion of the cost reduction accrues to the patient through lower deductible and coinsurance payments. This cost reduction is driven by the fact that, in general, ASC prices are significantly lower than hospital outpatient department (HOPD) prices for the same procedure in all markets, regardless of payer.

The study also looks at the potential savings that could be achieved if additional procedures were redirected to ASCs. As much as $55 billion could be saved annually depending on the percentage of procedures that migrate to ASCs and the mix of ASCs selected instead of HOPDs.

Finally, the study explores additional cost savings that would result if certain inpatient procedures, such as total joint replacements, continue to migrate to ASCs.

This study supplements an earlier review of Medicare costs by researchers at the University of California-Berkeley that showed that ASCs reduce Medicare costs by $2.3 billion annually. *Ambulatory Surgery Center Association, Medicare Cost Savings Tied to ASCs,* (2013), http://www.advancingsurgicalcare.com/medicarecostsavings.

Introduction and Purpose

The Medicare price differential for common outpatient services delivered in the hospital outpatient department (HOPD) vs. ambulatory surgery center (ASC) environment is well known and documented. On average, Medicare reimburses ASCs at 53 percent of the rate it reimburses HOPDs for the same procedure. The payment gap between services delivered at ASCs rather than HOPDs reduced the Centers for Medicare and Medicaid Services' (CMS) costs by more than $7 billion between 2007 and 2011[1].

While CMS payment rates are publicly available, commercial carrier payment rates are not. Therefore, less is known about the price differences and associated savings that exist between the ASC and HOPD environments for those employers and patients covered by commercial insurance (employer-sponsored insurance or private insurance purchased on the public exchanges and elsewhere).

The following analysis provides an estimate of the significant savings that ASCs currently provide to commercially insured patients, along with potential savings available to the commercially insured population, when shifting care to an ASC setting. This analysis was conducted in a partnership between Healthcare Bluebook, the Ambulatory Surgery Center Association (ASCA) and HealthSmart, a leading provider of third-party administrative services for self-funded employers.

Specifically, the paper discusses each of the following:

1. the estimated cost savings generated by ASCs in the commercially insured U.S. population;

2. the estimated additional cost reductions to be achieved if more cases were to be performed in ASCs;

3. the additional value created as traditional inpatient procedures migrate to ASC settings (e.g., total knee replacements); and

4. examples of HOPD and ASC price disparities within and across regions.

The ASC model was developed in 1970, and Medicare approved payments to ASCs for more than 200 procedures in 1982. Steady growth in the number of ASCs and the number of surgical procedures performed in the outpatient setting, including HOPDs, has continued since. This shift toward outpatient procedures has accelerated due to advancements in medical practice and technology that have reduced the need for overnight hospital stays.

---

[1] Department of Health and Human Services, Office of Inspector General, (2014, April). *Medicare and Beneficiaries Could Save Billions If CMS Reduces Hospital Outpatient Department Payment Rates For Ambulatory Surgical Center Approved Procedures to Ambulatory Surgical Center Payment Rates.* Retrieved April 11, 2016, from http://oig.hhs.gov/oas/reports/ region5/51200020.pdf

Today, many common surgeries are performed as outpatient procedures, and most patients, except those with complicated health conditions, can be served in the outpatient setting. Common ASC procedures include colonoscopies, cataract surgeries, tonsillectomies and arthroscopic orthopedic surgeries. CMS currently approves and reimburses 3,837 procedure codes in the ASC setting, and commercial populations are constantly expanding these boundaries. In fact, some ASCs are performing total joint replacements and other traditionally inpatient procedures with excellent outcomes.

While all HOPDs are hospital owned, most ASCs are at least partially owned by physicians, often in conjunction with hospitals and/or management companies. Sixty-five percent of the more than 5,400 Medicare-licensed ASCs in the U.S. are wholly owned by physicians and operate as small businesses.

A study published in *Health Affairs* analyzed data from the National Survey of Ambulatory Surgery and discovered that procedures performed in ASCs are more efficient, taking 25 percent less time than those performed in hospitals[2]. This efficiency, and corresponding cost-effectiveness, is due largely to the ASCs' focus on a limited number of procedures, their owner/operator culture and specialized nursing and support staff. Because ASCs specialize in providing outpatient surgery, they are able to deliver patient-care services efficiently and conveniently. For example, operating rooms are turned over quickly and are not interrupted by emergency cases. This enables physicians to commence their procedures in a timely manner and use their time more productively. Consequently, ASCs tend to be more convenient and cost effective than HOPDs while still providing excellent care.

[2] Munnich, E. L., & Parente, S. T. (2014). Procedures Take Less Time At Ambulatory Surgery Centers, Keeping Costs Down And Ability To Meet Demand Up. *Health Affairs*, 33(5), 764-769.

Patients Often Pay Dramatically Different Amounts for the Same Care in the Same Community

Healthcare prices vary dramatically even within the same insurance network and city. For example, in Charleston, West Virginia, the price of a cataract surgery, including payments to the anesthesiologist and physician, can vary from $2,684 to $8,662 depending on the facility where the surgery is performed (Figure 1). In this case prices vary by more than 300 percent, primarily due to the amount charged by the facility – not the physicians. These facility prices vary by almost 600 percent and total more than 70 percent of all dollars spent for cataract surgery in Charleston, WV.

Payments to anesthesiologists vary, partially due to the time component of anesthesia billing, but these payments are the smallest portion of the total cost and are dwarfed by payments to facilities.

Payments to physicians are a more significant portion of total cost, but physicians performing the most expensive cataract surgeries are paid approximately the same as physicians performing the least expensive surgeries. Thus, it is the choice of facility that drives the total price variation.

The consistency of payments to physicians indicates that most physicians are unable to differentiate themselves when negotiating payment rates from insurance companies and, hence, are paid similar rates. Facilities, on the other hand, vary significantly in their service

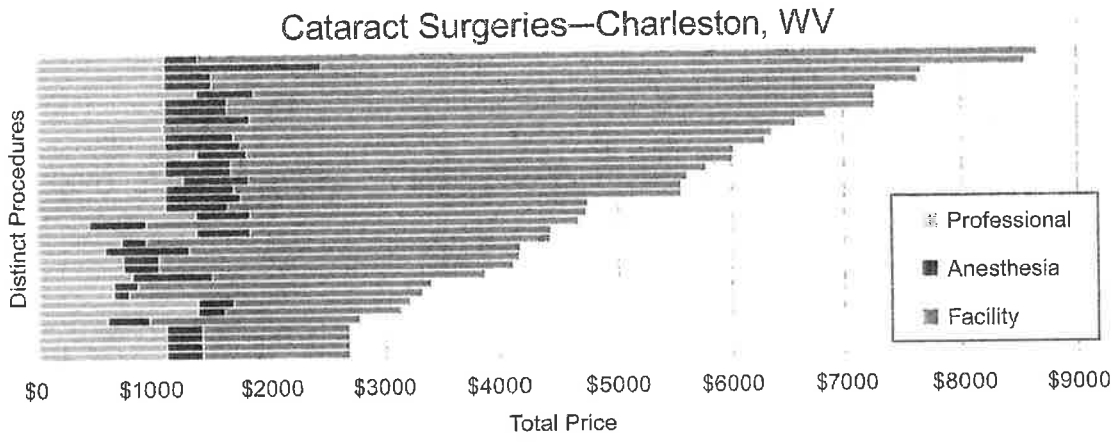


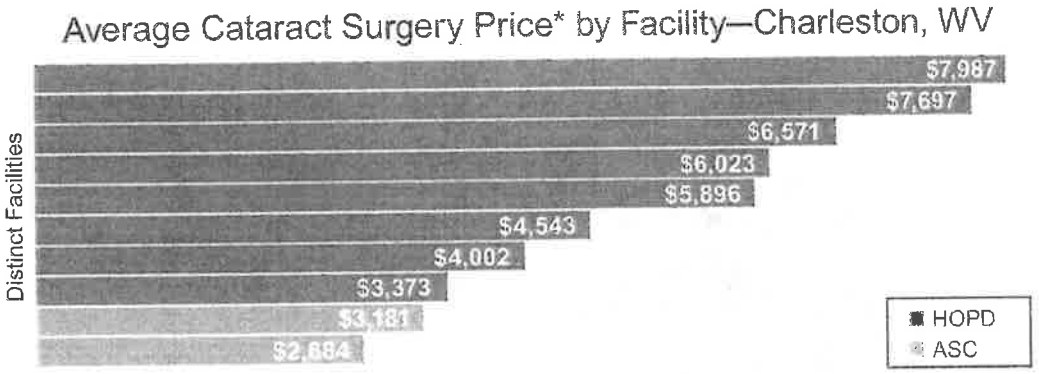
Figure 1

offerings and market power and, therefore, have significantly different negotiated rates with insurance companies.

For example, Hospital A provides emergency, inpatient and outpatient care. Hospital B offers everything Hospital A offers and also operates the only children's hospital in the metropolitan area. Due to this exclusive service line, Hospital B has better negotiating leverage with an insurance company. Importantly, this leverage applies not only to services uniquely performed in the children's hospital, but also to outpatient surgeries, such as cataract surgery, that are performed in other facilities in the area. Since the entire hospital is either in or out of network, all services are negotiated together, allowing Hospital B to demand higher reimbursement for procedures even though equally good, lower-priced alternative sites of service exist in that market area.

Since any ASC will offer fewer services than both Hospital A and B, those ASCs will have less negotiating leverage with commercial carriers and, therefore, often will receive lower reimbursement rates than either Hospital A or B if they want to be included in the insurer's network. While the efficiency inherent in the ASC model explains why ASCs can continue to exist when receiving significantly lower payments, it is the market power of hospitals that widens these price disparities[3] [4].

As a result of these factors, the total price of a procedure performed at an ASC is generally significantly lower than the total price of the same procedure performed in an HOPD. For example, the average price of cataract surgery at an ASC in Charleston, West Virginia, is $2,932, including the physician and anesthesiologist payments, while the average price at an HOPD is $5,762 (Figure 2). In this example,



* Includes allowed amounts for all claim components: anesthesia, professional and facility.

Figure 2

[3] Neprash, H.T., BA, Chernew, M.E., PhD, Hicks, A.L., MS, Gibson, T., PhD, & McWilliams, M., MD, PhD, (2015, October). Association of Financial Integration Between Physicians and Hospitals With Commercial Health Care Prices. *Journal of the American Medical Association.*

[4] The Robert Wood Johnson Foundation, Martin Gaynor, PhD & Robert Town, PhD. (2012, June). *The impact of hospital consolidation – Update.* Retrieved April 20, 2016, from http://www.rwjf.org/en/library/research/2012/06/the-impact-of-hospital-consolidation.htm

the average price for a cataract surgery at the least expensive facility was $2,684, including the payments to anesthesiologists and physicians. At the most expensive facility, the average price was $7,987. ASCs are at the low end of the spectrum and HOPDs are at the high end.

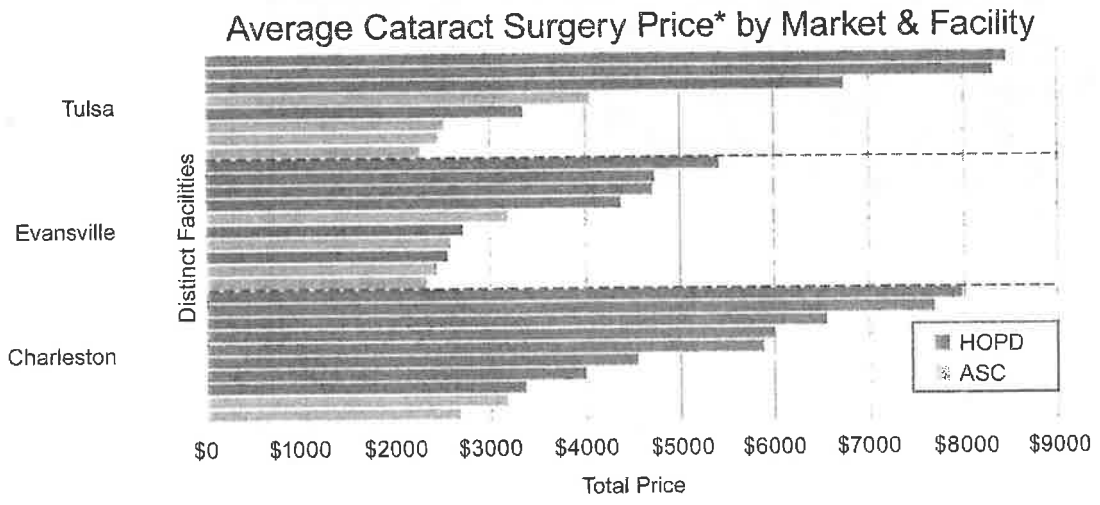
This commercial price differential between the ASC and HOPD environments is persistent across metropolitan areas (Figure 3), insurance carriers and procedure categories, with the degree of price variability related to local market factors.

Summary of Methodology

All analysis was conducted using a sample of de-identified commercial claims data for calendar year 2014 from HealthSmart. This data represents more than 400,000 lives across all regions of the U.S. The CMS list of ASC-eligible procedure codes, with a few additions reflecting those prevalent in a commercial population (pediatric-related codes, OB/GYN-related codes, etc.), was used to identify the spending on procedures that can be performed in an ASC.

Total price of service was included in the analysis (facility fees, professional fees and anesthesia fees, where relevant). Based on the commercial population considered, these services accounted for about 19 percent of total medical spend, or $890 per person for the year. All prices are calculated using the "allowed" amount, which reflects the actual amount a provider received after any discounts were applied.

Thirteen high-volume outpatient procedures were used as proxies to analyze the price differential between the ASC and HOPD environments and estimate the percentage of spending that could be saved by performing the procedures in ASCs instead of HOPDs. An adjustment was made to account for the fact that some high-risk patients are not candidates



* Includes allowed amounts for all claim components: anesthesia, professional and facility.

Figure 3

for ASC-based care (patients with high comorbidities are traditionally directed to an HOPD in order to be closer to critical-access care). This adjusted percentage was applied to the $890 ASC-eligible spend per person and then scaled by the commercially insured U.S. population to estimate the national savings potential.

All estimates are based on the calendar year 2014 data. No adjustments were made to account for population aging or increasing utilization of ASC-eligible services. (See Appendix A: Methodology and Appendix B: Adjustments for ASC Ineligibility for a more detailed explanation of the methodology.)

Current ASC Use Reduces Private Healthcare Costs by $38 Billion Annually

The lower cost of care in ASCs relative to HOPDs saves employers and consumers tens of billions of dollars a year. For the commercially insured population in the U.S., an estimated $37.8 billion is saved annually by using ASCs. Stated differently, if all of the procedures currently performed in ASCs for the commercially insured population in the U.S. were performed in HOPDs, the cost of those procedures would increase by $37.8 billion in just one year.

Annual Savings from Procedures Performed in ASCs	
% of Common ASC Procedures Currently Performed at ASCs	48%
Current Annual Savings	$37.8 B
Potential Additional Annual Savings	$38.2 B
Potential Additional Annual Savings from Optimal Migration to ASCs	$55.6 B

Potential Cost Reductions Attributed to ASCs

Despite the savings detailed above, for commercially insured populations, only 48 percent of procedures commonly performed in ASCs are actually performed in ASCs. If the remaining 52 percent were performed at ASC price points, an additional $41 billion in healthcare costs could be saved annually.

As a practical matter, ASCs would not be the appropriate setting for a small percentage of patients (e.g., those with serious health issues) currently treated in HOPDs. For example, patients on dialysis (0.1 percent of Americans) are not ASC eligible for certain procedures. When ASC-ineligible cases are accounted for, the total potential annual savings from performing the surgeries in ASCs instead of HOPDs is $38.2B. (This assumes 3 percent of relevant cases are ASC ineligible. See Appendix B: Adjustments for ASC Ineligibility.)

The average ASC price, however, is a blend of both lower-priced and higher-priced ASCs. The optimal migration of cases would shift cases from HOPDs to the local low-price ASCs. If patients were directed to low-price ASCs only, the potential annual savings increases from $38.2 billion to $55.6 billion.

Migrating a meaningful number of patients to lower-cost ASC settings would, undoubtedly, also have the added benefit of causing HOPDs

to consider price reductions in order to maintain their market share. While this study did not attempt to model the competitive reactions of HOPDs if confronted with a significant loss of patient volume, fundamental economic principles as well as a recent study that looked at the impact of reference-based pricing on patient choices concluded that hospitals did, in fact, lower their pricing for certain procedures in response to a loss of market share to competing ASCs[5].

Potential Savings Can Grow if ASCs Can Perform More Complex Procedures

With advances in surgical techniques, pain management and post-surgical care, more procedures traditionally performed in the inpatient setting are being shifted to ASCs. This creates an expanding frontier for reducing healthcare costs. As an example, total hip and total knee replacements, which currently account for about 1.5 percent of total medical spend, are now being performed safely in ASCs in a limited number of markets. The potential savings are significant. Assuming that the price differential and the rate of ASC ineligibility due to comorbidities for total joint replacement will be commensurate with other outpatient procedures, $3.2 billion could be saved by moving total hip and knee replacements to ASCs. (See Appendix A: Methodology.)

Projected National Cost Reductions

To realize the potential cost reductions highlighted above, several things need to happen. On the supply side, ASC capacity will have to double in order to support the migration from HOPDs.

On the demand side, patients must be educated and incentivized to choose ASCs for their outpatient procedures. As premiums rise and adoption of high-deductible health plans increases, patients have greater incentives to reduce their costs by choosing ASC-based care, but education is lacking. Though healthcare transparency has made significant advancements in recent years, most patients are still unaware of the lower costs that ASCs offer.

Even modest changes in market share produce massive savings for the entire health system. For example, if an additional 5 percent of current HOPD cases were moved to ASCs annually over the next ten years, $113.8 billion would be saved compared to current utilization rates (Table 1). This assumes that the annual potential ASC savings is currently $41.4 billion:

Ten-Year Savings Projection

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total
Potential Savings	$41.4 B	$41.4 B	$41.4 B	$41.4 B	$41.4 B	$41.4 B	$41.4 B	$41.4 B	$41.4 B	$41.4 B	**$413.7 B**
Percent of Savings Captured	5%	10%	15%	20%	25%	30%	35%	40%	45%	50%	**28%**
Savings	$2.1 B	$4.1 B	$6.2 B	$8.3 B	$10.3 B	$12.4 B	$14.5 B	$16.5 B	$18.6 B	$20.7 B	**$113.8 B**

Table 1

[5] Robinson, J., et. al. (2015, March). Reference-Based Benefit Design Changes Consumers' Choices And Employers' Payments For Ambulatory Surgery. *Health Affairs*.

$38.2 billion from current ASC-eligible procedures above plus $3.2 billion from total knee and hip replacement.

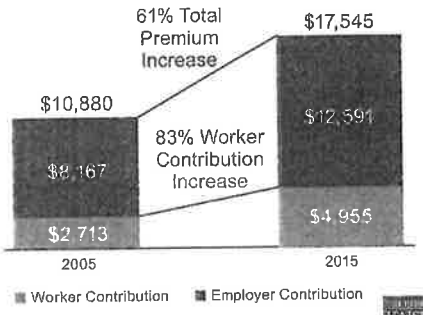
For ASC eligible procedures in this study, patients were responsible for 15 percent of the cost on average. That would mean $17.1 billion in reduced costs for patients over the next ten years (Figure 4). If 3 percent or 8 percent of HOPD cases were moved to ASCs annually, ten-year savings would be $68.3 billion and $182 billion respectively (Table 2).

Projected National Cost Reduction	
Plan Sponsor Savings	$96.7 B
Patient Savings	$17.1 B
Total Savings	$113.8 B

Figure 4

These estimates do not account for inflation or upward trends in medical spending. They also do not take into account the potential that HOPD pricing will decrease in order to compete with ASCs, which would create further outpatient savings. As referenced above, in the CalPERS reference pricing program, high-priced providers will reduce prices to be competitive and attract price-sensitive consumers.

Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2005-2015



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005-2015

Reducing Costs for Employers and Employees

From 2005 to 2015, average health insurance premiums for employer-sponsored family coverage increased 61 percent, from $10,880 to $17,545 per year. To combat these rising costs, employers have increasingly adopted Consumer Driven Health Plans (CDHP) and account-based plan types, shifting costs to employees. This has driven the average employee's share of healthcare spending up 81 percent in the same time period, from $2,713 to $4,955[8] annually. This highlights the need for programs like price transparency that can help patients identify better value providers within their networks so that employers and their employees both can lower costs.

Ten-Year Savings Projections

	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	Total
Savings at 3% Additional Capture	$1.2 B	$2.5 B	$3.7 B	$5.0 B	$6.2 B	$7.4 B	$8.7 B	$9.9 B	$11.2 B	$12.4 B	**$68.3 B**
Savings at 5% Additional Capture	$2.1 B	$4.1 B	$6.2 B	$8.3 B	$10.3 B	$12.4 B	$14.5 B	$16.5 B	$18.6 B	$20.7 B	**$113.8 B**
Savings at 8% Additional Capture	$3.3 B	$6.6 B	$9.9 B	$13.2 B	$16.5 B	$19.9 B	$23.2 B	$26.5 B	$29.8 B	$33.1 B	**$182.0 B**

Table 2

[8] Henry J. Kaiser Family Foundation. (2015, September). *Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005–2015*. Retrieved April 10, 2016, from http://kff.org/health-costs/report/2015-employer-health-benefits-survey/

For example, in Charlotte, NC, the average ASC price for a knee arthroscopy was $6,118, while the average HOPD price was $12,493, more than twice as expensive. That means $6,375 is saved on average in Charlotte, NC, when a patient chooses an ASC for a knee arthroscopy. How those savings are divided between the payer and the patient depends on the plan design.

For a knee arthroscopy in Charlotte, NC, if a patient has a Silver Plan as defined by the Affordable Care Act, with a $2,700 deductible, 80 percent coinsurance and $5,000 maximum out of pocket, the patient would save $1,275—more than the median family's weekly income. The remaining $5,100 would be saved by the payer. For self-funded employer-sponsored insurance, that is $5,100 directly to the bottom line for the employer.

Applying the same plan design to the earlier example of cataract surgery in Charleston, WV, a patient would save $566 by choosing an ASC instead of an HOPD. This is a significant savings in a geographic area where annual income per capita is less than $35,000[7]. The payer would realize an additional savings of $2,264.

Estimating Savings for Self-Insured Populations

For employers that self insure, it is reasonably straightforward to estimate the potential cost reductions from ASCs for their covered employees. With $890 in ASC-eligible spending per commercially insured person and 20.6 percent savings opportunity from moving all ASC-eligible cases from HOPDs to ASCs, $183 in potential ASC savings exists per commercially insured person. A self-funded employer with 1,000 employees is normally covering more than 2,000 lives, when employees and dependents are counted, which means a potential ASC-based savings of more than $366,000 for the employer and employees.

Conclusion

Billions of dollars spent each year on commercially insured outpatient surgeries and procedures can be reduced, without compromising quality, if more cases migrate to ambulatory surgery centers. While a small percentage of patients have health conditions that require outpatient care to be received in proximity to a full-service hospital should complications arise, most patients can receive the same level of care at lower cost by seeking treatment in an ASC. Advances in medical technology and pain control are allowing increasingly complex procedures, such as total joint replacements, to be performed in an outpatient setting.

Policymakers, insurers, employers and beneficiaries all have a shared interest in reducing healthcare costs, and the $38 billion in annual savings identified in this study highlight the role that ASCs already play in controlling these costs. Strategies should be implemented to generate additional savings by ensuring that the most efficient site of service for outpatient care is selected whenever possible. In particular, innovative plan design and increased consumer awareness of the benefits of receiving care in an ASC can save thousands of dollars per procedure.

---

[7] United States Census Bureau. (2014). *2010–2014 American Community Survey 5-Year Estimates.* Retrieved April 30, 2016, from http://www.census.gov/

About the authors/organizations

Ambulatory Surgery Center Association (ASCA)

ASCA is the national membership association that represents ASCs of all specialties and provides advocacy and resources to assist ASCs in delivering high quality, cost-effective ambulatory surgery to all the patients they serve.

Healthcare Bluebook

Healthcarebluebook.com, headquartered in Nashville, TN, is a leading provider of health-care price and quality transparency solutions to employers, third-party administrators (TPA), health plans and provider organizations. Healthcare Bluebook products help employers and employees save money by enabling consumers to understand local health-care prices, compare providers on price and quality and shop for care anywhere in the U.S.

HealthSmart

For more than 40 years, HealthSmart has offered a wide array of customizable and scalable health-plan solutions for self-funded employers. HealthSmart's comprehensive service suite addresses individual health from all angles. This includes claims and benefits administration, provider networks, pharmacy, benefit-management services, business intelligence, onsite employer clinics, care management, a variety of health and wellness initiatives and Web-based reporting.

Appendix A: Methodology

Data Source

All analysis was conducted using a national sample of de-identified commercial claims for calendar year 2014.

Estimating Potential ASC Savings for the Commercially Insured U.S. Population

The estimated potential ASC savings for the commercially insured U.S. population is calculated as:

Equation 1

Addressable Spend per Commercially Insured Person $890	X	Percent Savings from ASCs 20.6%	X	Commercially Insured Population 208.6M

Estimating the Addressable Spend per Commercially Insured Patient

The addressable spend is the expenditure on any procedure that could be performed in an ASC for an ASC-eligible patient, whether that patient is ASC eligible or not. (Adjustments for ASC ineligible are made later in the process. See Appendix B: Adjustments for ASC Ineligibility.) All prices are calculated using the allowed amount, which is the actual amount a provider receives after any discounts are applied.

CMS currently covers 3,837 procedure codes in the ASC setting. Procedure codes from select Healthcare Bluebook ShopSmart™ procedures were added to the CMS list to produce a complete ASC-eligible procedure code list. These procedure codes were used to identify procedures in one

year of medical-claims data. For each procedure performed in an ASC or HOPD, the total anesthesia, professional and facility payments were included as part of the procedure price. All office-based, inpatient-based and emergent care was excluded. When the total payments from this process were divided by the total members in the represented population, the annual addressable spend per person was $890.

Estimating Percent Savings from ASCs

To estimate the percent savings from ASCs, thirteen high-volume procedures were used as proxies to represent all ASC procedures. These procedures were selected for their high volume and standardization. The average ASC price was calculated for each procedure in each metropolitan market across the U.S.

The potential ASC savings is the sum of the differences between the price of each HOPD case and the average ASC case price for that metropolitan market and procedure combination. Market and procedure combinations with limited data volume were excluded.

Equation 2

$$potential\ ASC\ savings = \sum_{m,p,h} cost_{m,p,h} - average\_ASC\_price_{m,p}$$

m = market
p = procedure
h = HOPD case

To produce the ASC savings as a percentage, the potential ASC savings was divided by the total spend for all analyzed markets and procedures and multiplied by one hundred.

Equation 3

$$percent\ savings\ from\ ASCs = \sum_{m,p,h} \frac{potential\ ASC\ savings}{total\ spend} \times 100$$

Estimating Potential Savings from Total Hip & Total Knee Replacements

To estimate potential savings from moving total hip and knee replacements to the ASC setting, Equation 1 from above was used, but with $73.59 as the addressable spend per commercially insured person. This represents 1.5 percent of total medical spend per commercially insured person. The 20.6 percent savings opportunity was not changed because there are not currently enough markets offering ASC-based joint replacement to use as a representation of the entire U.S. However, the savings opportunity may be as much as double this estimate based on markets that currently have ASC-based total joint replacements.

Appendix B: Adjustments for ASC Ineligibility

Some patients will not qualify for treatment in an ASC setting due to comorbidities or other complicating factors. To account for this, potential ASC savings were estimated using three assumptions for what percent of the commercially insured population is ASC ineligible: 1 percent, 3 percent and 7

percent. These percentages were selected based on prevalence rates for three common conditions that may make patients ineligible for care at an ASC for some procedures (Table 3).

Seven percent ASC ineligibility is the upper limit of this sensitivity analysis since it is the sum of the prevalence rates of all three conditions, which are not independent and which don't necessarily disqualify patients from ASC-based care. For example, a patient with a body mass index (BMI) of 41 could still be cared for in an ASC for most if not all procedures performed in an ASC. However, a patient with a BMI of 45 would qualify for fewer procedures in an ASC setting.

Three percent was selected as the expected rate of ASC ineligibility in a commercially insured population. This, however, could still be an overestimation, so we have also included the one-percent ASC-ineligibility threshold.

For each of these ASC-ineligibility rates, a corresponding number of cases per market/procedure combination were assumed to be performed at the average HOPD price and excluded from the migration calculation. See Table 4 for the sensitivity impact on estimated savings.

Common Conditions that Effect ASC Eligibility

Condition	Prevalence (% of U.S Population)	Notes
Latex Allergy	< 1%	Some ASCs are not equipped with a latex-free operating room.
CKD (with Dialysis)	0.1%	Not a disqualifying condition for all procedures performed in ASCs.
BMI > 40	6.3%	Patients with BMI > 45 are almost always ASC ineligible. Not all patients with BMI between 40 and 45 are ASC ineligible.

Table 3

Effect of ASC-Ineligibility on Potential Savings

	Savings as % of Total Addressable Spend	Potential Annual Savings
0% ASC Ineligible	22.1%	$41.0 B
1% ASC Ineligible	21.6%	$40.1 B
3% ASC Ineligible	20.6%	$38.2 B
7% ASC Ineligible	18.6%	$34.5 B

Table 4

Appendix C: Savings Examples

Procedure prices in most U.S. markets can vary by as much as 500 percent. In most cases, when present, ASCs provide the best value.

Procedure	Market	Lowest Price Provider Type	Lowest Price	Average ASC Price	Average HOPD Price	Average Price Difference
Cataract Surgery	Charleston, WV	ASC	$2,684	$2,932	$5,762	$2,830
Cataract Surgery	Evansville, IN	ASC	$2,450	$3,316	$6,992	$3,676
Cataract Surgery	Tulsa, OK	ASC	$2,248	$2,249	$3,833	$1,335
Knee Arthroscopy	Fayetteville, NC	ASC	$5,924	$7,658	$11,575	$3,917
Knee Arthroscopy	Charlotte, NC	ASC	$5,664	$6,118	$12,493	$6,375
Knee Arthroscopy	Tulsa, OK	ASC	$2,627	$2,844	$4,807	$1,963
Knee Arthroscopy	Phoenix, AZ	ASC	$2,355	$2,972	$4,306	$1,334

ASCA's CAMPAIGN FOR
Advancing Surgical Care
Quality for Patients. Value for Healthcare

The ASC Cost Differential

Ambulatory Surgery Centers (ASCs) perform more than 7 million procedures for Medicare beneficiaries needing same-day surgical, diagnostic and preventive procedures. By specializing in specific procedures, ASCs are able to maximize efficiency and quality outcomes for patients.

On average, the Medicare program and its beneficiaries share in more than $2.3 billion in savings each year when patients receive certain preventive and surgical procedures at ASCs instead of other outpatient surgical facilities such as hospital outpatient departments (HOPDs). Because ASCs perform specific services and do so more efficiently, Medicare reimburses ASCs as a percentage of the amount paid to HOPDs.

In 2003, Medicare procedures performed in ASCs cost 83% of the amount paid to hospital outpatient departments for the same services. Today, procedures performed in the ASC cost Medicare just 53% of the amount paid to HOPDs. For example, Medicare pays hospitals $1,745 for performing an outpatient cataract surgery while paying ASCs only $976 for performing the same surgery. Beneficiary savings are also significant:

Cataract Surgery (66984)	Medicare Fee	Beneficiary Fee
ASC	$780.00	$195.00
HOPD	$1,396.00	$349.00

Private insurance companies tend to save similarly, which means employers also incur lower health care costs when employees utilize ASC services. For this reason, both employers and insurers have recently been exploring ways to incentive the movement of patients and procedures to the ASC setting. A review of commercial medical-claims data found that U.S. heath care costs are reduced by more than $38 billion per year due to the availability of ASCs as an alternative, high quality setting for outpatient procedures. More than $5 billion of that cost accrues directly to patients through lower deductible and coinsurance payments.

Different Inflation Measures

This growing divergence in payments is driven, in part, by differences in how the payment systems are updated each year to account for inflation.

Despite the fact that ASCs and HOPDs offer the same services, the Centers for Medicare & Medicaid Services (CMS) applies two different measures of inflation to update each payment system.

For HOPDs, CMS uses the hospital market basket, which measures the cost of medical expenses. For ASCs, CMS uses the Consumer Price Index –Urban (CPI-U), which measures the cost of goods such as milk and bread. Not only is the CPI-U based on changes entirely unrelated to medical costs, the inflation update is historically lower than the hospital market basket.

Updated using 2016 payment rates. 8/2016

Connect with ASCA:

MIGRATING SURGICAL PROCEDURES TO AMBULATORY SURGERY CENTERS

Q What are the current trends in ambulatory surgery center (ASC) case mix and volume growth? Which specific procedures will continue or begin to shift to this care setting, and what factors will impact future procedure migration?

Overview

ASCs excel at standardizing procedures, cutting waste and maximizing efficiencies in the OR, all while consistently providing patients and surgeons with an excellent experience. While procedural volume at ASCs is robust, both the number of new ASCs and the percentage of overall surgical procedures performed at those facilities have remained flat over the past few years. There are several factors that likely will stimulate the shift of procedures to outpatient venues in general and ASCs in particular, but the shift is expected to remain modest.

As surgical care improves, more patients and procedures will be eligible for ambulatory surgery. Although ~70% of surgery in the US is performed on an outpatient basis, evidence indicates the ceiling has not yet been reached and more procedures will migrate from inpatient to outpatient venues.

Medicare reimbursement rates have consistently favored hospital outpatient departments (HOPDs) for ambulatory surgery, and today ASCs receive almost 50% less payment than HOPDs for the same procedures. Elimination of this differential, so-called site neutrality, continues to be a contentious issue in Washington. However, despite greater reimbursement for HOPDs, many hospitals are aggressively acquiring ASCs or participating with physicians in joint venture arrangements to have an ownership presence in the ASC market.

Regardless of the outcome of the site-neutrality issue, commercial payers will increasingly use means at their disposal, including active and passive steerage and reference pricing, to encourage patients and providers to perform procedures at the lowest possible cost setting. Likewise, health care organizations on a "value-based" mission to provide high-quality, low-cost care will view ASCs as a key component of their long-term strategy.

Ambulatory Surgery Center Landscape

From 2000 to 2010, the number of Medicare-licensed ASCs in the US grew nearly 70% from 3,028 to 5,135. But from 2010 to 2015, the number increased only by about 1% annually to approximately 5,500. An estimated 20 to 25 million procedures are performed annually at ASCs, generating $15 to $20 billion in annual gross revenue.

The current ASC case mix is dominated by 4 service areas—gastrointestinal (GI) endoscopy, ophthalmology, orthopedics and pain management—accounting for approximately 70% of all ASC volumes (Table 1). This case mix has been stable for the past several years as noted by MedPAC, which recently reported that from 2009 to 2014 there was little change in the top 20 most commonly performed ASC procedures in terms of the *types of procedures performed* as well as the *percentage of total ASC volume* of each procedure.

MIGRATING SURGICAL PROCEDURES TO ASCs

TABLE 1. HIGHEST-VOLUME ASC PROCEDURES

PROCEDURE	% MEDICARE VOLUME (2014)
Cataract w/ IOL (Lenses)	18.6
Upper GI Endoscopy	8.5
Colonoscopy and Biopsy	6.0
Lesion Removal Colonoscopy	5.4
Injection Foramen Epidural—Lumbar, Sacral	4.6
Postcataract Laser Surgery	4.5
Injection Spine—Lumbar, Sacral	3.4
Injection Paravertebral—Lumbar, Sacral	2.8

IOL = intraocular lens. **Source:** MedPAC, *Report to Congress: Medicare Payment Policy.* March 2016.

Continued shift of procedures from HOPDs to ASCs is anticipated for a number of reasons. As patients are exposed to greater out-of-pocket costs for health care, low-cost, high-quality providers like ASCs will become increasingly attractive. Several factors that may further stimulate HOPD-to-ASC procedure migration in the next decade include a growing list of ASC-eligible procedures (eg, cervical fusions), technology innovation that improves procedure safety and physician confidence in the ASC setting. The largest influence, though, will be payment models that encourage lower-cost care and a growing payer and patient perception of ASCs as the most cost-effective surgical care site. In particular, increases in patient contribution to the cost of care (due to high insurance deductibles, copayments and/or coinsurance fees) will greatly influence where individuals choose to receive surgical care.

Cost of Care Will Increasingly Guide Patient Choices

According to the 2016 Kaiser Employer Health Benefits Survey, the percentage of workers enrolled in a plan with an annual deductible of $1,000 or more for single coverage increased from 10% in 2006 to 51% in 2016. As patients are exposed to greater out-of-pocket costs, it's expected they will increasingly focus on cost and care value when selecting a provider for outpatient surgery. For many patients, an ASC will likely be the least-expensive and highest-quality option in their market.

Given that procedures performed in ASCs are fairly standard and typically accomplished in substantial volumes, they are a natural place for price transparency to gain traction. The Surgery Center of Oklahoma has published all-inclusive prices for 100 procedures since 2009, many of which are far below HOPD rates in their market. The strategy has spurred at least 5 other ASCs in the state to follow suit. In North Carolina, Blue Cross and Blue Shield unveiled a free online price transparency tool—Health Cost Estimator—that allows patients to look up prices by provider. Sg2 predicts that such price transparency initiatives will become increasingly common over the next several years.

Key ASC Characteristics

Impact—Patients

Patients in high-deductible health plans (HDHPs) or plans with separate copays for outpatient surgery are likely to spend more time shopping for the lowest-cost, highest-value option for outpatient surgery, making ASCs an attractive option.

To illustrate the cost difference between ASCs and HOPDs, Table 2 lists average allowable payments to outpatient surgery providers in Virginia by insurers. Note that differences in facility fees represent the bulk of the difference in total procedure cost.

MIGRATING SURGICAL PROCEDURES TO ASCs

TABLE 2. ESTIMATED PROCEDURE COSTS, ASC VS HOPD

PROCEDURE	CARE SETTING	ESTIMATED TOTAL COST (INCLUDING FACILITY FEE)	ESTIMATED FACILITY FEE
Colonoscopy	ASC	$1,619	$826
	HOPD	$2,484	$1,806
Gallbladder Surgery	ASC	$6,994	$5,024
	HOPD	$9,461	$7,468
Hernia Repair	ASC	$4,367	$2,963
	HOPD	$6,221	$4,787
Tonsillectomy With Adenoidectomy	ASC	$3,297	$2,312
	HOPD	$5,324	$4,171
Endoscopy	ASC	$1,611	$872
	HOPD	$2,607	$1,944

Source: Virginia Health Information. Healthcare pricing transparency. Accessed January 13, 2017.

In addition to lower costs, ASCs can provide a superior patient experience. They are often located in more convenient locations for patients, can be accessed more quickly than large hospital campuses, and may offer more comfortable and welcoming common areas/rooms. *Satisfaction among patients (and providers) is consistently higher at ASCs compared with hospital-based locations.*

Impact—Physicians

According to MedPAC, 91% of ASCs have at least some physician owners, and 74% are either wholly owned by physicians or a physician-hospital joint venture. In addition to their usual professional fee, these surgeon owners also capture a portion of the facility fee paid to the ASC for each procedure. For many surgeons, the financial and operational benefits of practicing in a facility in which they have an ownership stake make ASCs particularly attractive.

Furthermore, ASCs offer a substantial degree of surgeon autonomy in terms of scheduling, control of the patient experience and influence of supplies/preference items. ASCs do not handle urgent or emergent cases, therefore patient throughput is optimized and surgeons can enhance their procedural volumes. Finally, providers are increasingly implementing employed models in which they are more closely aligned with hospitals. As hospitals take on greater ownership of ASCs, they will encourage providers to use these facilities to either free up necessary capacity at inpatient venues and/or perform surgery at lowest-cost locations.

Key Operational Differences Between ASCs and HOPDs

There are many factors that allow ASCs to operate more efficiently and at a lower cost to patients than HOPDs. These include:

- **Greater standardization and scheduling predictability.** Many ASCs focus on a single specialty—often GI endoscopy or orthopedics—or a few key specialties. This allows them to tailor the ORs to the unique needs of the specialty and/or surgeon and to standardize OR supplies, procedure techniques, and patient throughput and room turnover protocols. The result is shorter case times and more efficient OR utilization. In fact, studies have shown that total perioperative times are 39% to 50% faster in ASCs than in HOPDs. Additionally, surgeon block times are much less likely to be disrupted and a greater percentage of OR time can be blocked out for individual surgeons.
- **Younger, healthier patients.** ASC patients are typically younger and healthier than those treated in HOPDs. Thus, ASC procedures are lower risk and can result in better outcomes, faster throughput and fewer complications.
- **Lower regulatory burden.** Although requirements vary by state, ASCs generally face less stringent and burdensome accreditation, licensing and regulatory requirements than HOPDs.

MIGRATING SURGICAL PROCEDURES TO ASCs

Future Procedure Shifts

The decision to shift procedures from HOPDs to ASCs is driven by both "clinical" and "political" considerations. Decision factors include:

Clinical

- **Patient acuity:** How healthy are individual patients? More complicated surgeries (eg, joint replacement, laparoscopic cholecystectomy) are likely to shift to ASCs for younger, healthier patients with fewer comorbidities.
- **ASC capabilities:** Can the ASC perform a procedure as safely and effectively as an HOPD? Is a procedure high-volume and low-risk and fairly routine in terms of when it needs to be performed (elective vs emergent), potential complications or added complexities during surgery, perioperative times, and likely patient outcomes? Does the ASC have all the necessary equipment and supplies?

Political

- **Payment:** Is the procedure included in Medicare's list of ASC-approved procedures? Will the ASC be reimbursed by major private payers for a given procedure?
- **Physician preference:** Do local surgeons prefer to perform surgery in an HOPD or ASC? Do they have incentives, financial or otherwise, to use the ASC?
- **Patient preference**: Do patients prefer an ASC to save money given increases in HDHPs and cost-sharing? For convenience and ease of access?

Based on these factors, Table 3 provides an updated outlook for ambulatory surgery with special attention to ASC shift for a number of prominent specialties.

TABLE 3. PROCEDURES POTENTIALLY SHIFTING TO ASCs

SERVICE LINE	PROCEDURES	COMMENTS
Otolaryngology (ENT)	• Myringotomy (acute inner ear infections and chronic dizziness) • Tonsillectomy and/or adenoidectomy • Tympanoplasty • Sinus procedures	• ENT procedures are currently performed almost exclusively in the OP setting and would be quite suitable for the ASC environment. • ENT providers have not traditionally had significant ownership in ASCs, but as hospitals increase ownership look for employed ENT providers to migrate to ASCs.
Gastroenterology/ Endoscopy	• All diagnostic endoscopy • Most therapeutic endoscopy	• GI endoscopy is already one of the largest single categories of ASC procedures; Sg2 expects cases will continue to shift to ASCs. • GI surgeons have been among the most aggressive in ASC ownership.
General Surgery	• Most appendectomies • Hernia repair • Laparoscopic cholecystectomy • Breast surgery (both benign and malignant) • Wound debridement • Excision skin lesion	• Medical management of appendicitis continues to gain traction, converting IP appendectomies into delayed elective OP laparoscopic procedures. • Routine hernia repairs are already largely outpatient; "political" factors described above will stimulate shift from HOPDs to ASCs. • Laparoscopic cholecystectomies are largely outpatient, but not in all areas of the country. We expect the outpatient percentage to continue to increase and a substantial portion will wind up in ASCs. • General surgeons have not traditionally had significant ownership in ASCs, but as hospitals increase ownership look for employed surgeons to migrate to ASCs.

MIGRATING SURGICAL PROCEDURES TO ASCs

TABLE 3. PROCEDURES POTENTIALLY SHIFTING TO ASCs (Cont'd)

SERVICE LINE	PROCEDURES	COMMENTS
Ophthalmology	• Cataract procedures • Glaucoma procedures	• Ophthalmology is already a significant component of overall ASC volumes. • Significant increases in volumes are likely as the population ages.
Orthopedics/Spine	• Knee and shoulder arthroscopies • Laminectomy • Vertebral augmentation • All spinal injections • Total joint replacement • Excision of knee cartilage • Bunionectomy • Carpal tunnel release • Rotator cuff and tendon sheath repairs	• Injections for back pain are already a significant component of the ASC case mix and will continue shifting from HOPDs to ASCs. • Orthopedic volumes are a significant portion of overall surgical volumes and costs, so expect organizations to focus efforts to direct procedures to lowest-cost venues. • Anticipate the majority of total joint replacements to be performed in OP settings, including ASCs, especially for healthier, younger patients.
Urology	• Therapeutic endoscopic procedures (eg, transurethral resection of bladder tumors) • Endoscopic treatment of urinary calculi • Minimally invasive treatment of benign prostatic hyperplasia	• With exception of major cancer surgery, most urology procedures and virtually all endoscopic procedures are performed on an ambulatory basis. • ASC barriers for urologists in the past have been related to capital expenses for urology-specific equipment; however, larger groups and hospital ownership have shown willingness to invest to move significant procedural volume to ASCs.
Pulmonology/ Thoracic Surgery	• Most diagnostic bronchoscopies • Some therapeutic bronchoscopies • Mediastinoscopy	• Bronchoscopy volume is increasing and most procedures will be performed as outpatient.

ENT = ear, nose and throat.

Sg2 RESOURCES

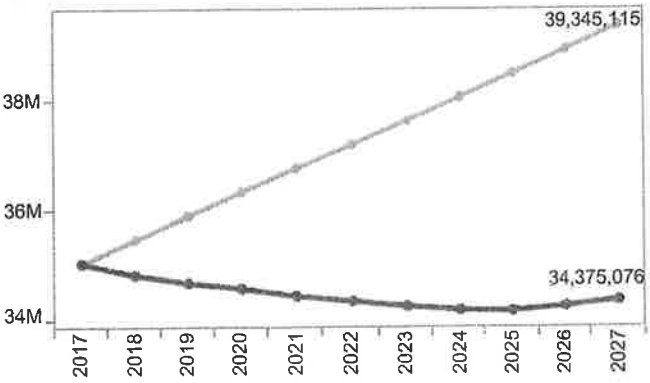
- Report: *Engaging the New Health Care Consumer*
- Report: *Surgery Service Line Forecast 2016*
- System of CARE Guide: *Linking Ambulatory Surgery Centers to Systems of CARE*
- Webinar: Surgery Update: Exploring the Outpatient Shift

Sources: Dyrda L. 15 statistics on surgery center payer mix. *Becker's ASC Review.* January 23, 2014; Cullen K et al. *National Health Statistics Reports: Ambulatory Surgery in the United States, 2006.* US Department of Health and Human Services, 2009; Hair B et al. *Am J Surg.* 2012;204:23–27; Munnich EL and Parente ST. *Health Aff (Millwood).* 2014;33:764–769; Kaiser Family Foundation. *2016 Employer Health Benefits Survey.* September 14, 2016; VMG Health. *Multi-Specialty ASC Intellimarker.* 2012 and 2016; MedPAC. *Report to Congress: Medicare Payment Policy.* 2014 and 2016; Virginia Health Information. 2015 Healthcare Pricing Transparency. Accessed January 2017; Blue Cross Blue Shield of North Carolina. Accessed April 17, 2014; Shinkman R. Oklahoma surgery center's transparency sparks price war. *FierceHealthcare.* July 22, 2013; Healthcare Cost and Utilization Project. *Statistical Brief #188: Surgeries in Hospital-Owned Outpatient Facilities, 2012.* Agency for Healthcare Research and Quality. February 2015; Sg2 Analysis, 2014, 2016.

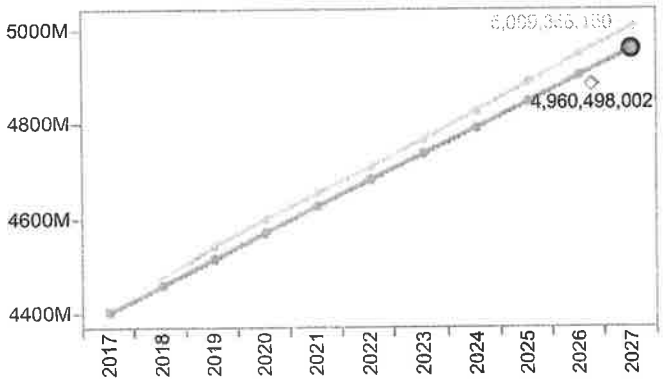
How is utilization projected to change by service line?

Sg2 Forecast Population Forecast

Inpatient Discharges
10-Year Discharge Change by Year

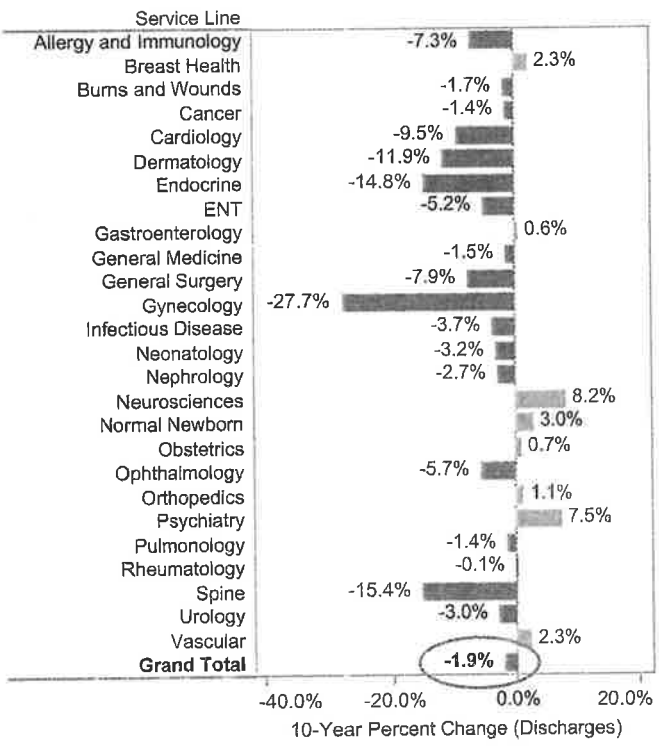


Outpatient Volumes
10-Year Volumes Change by Year



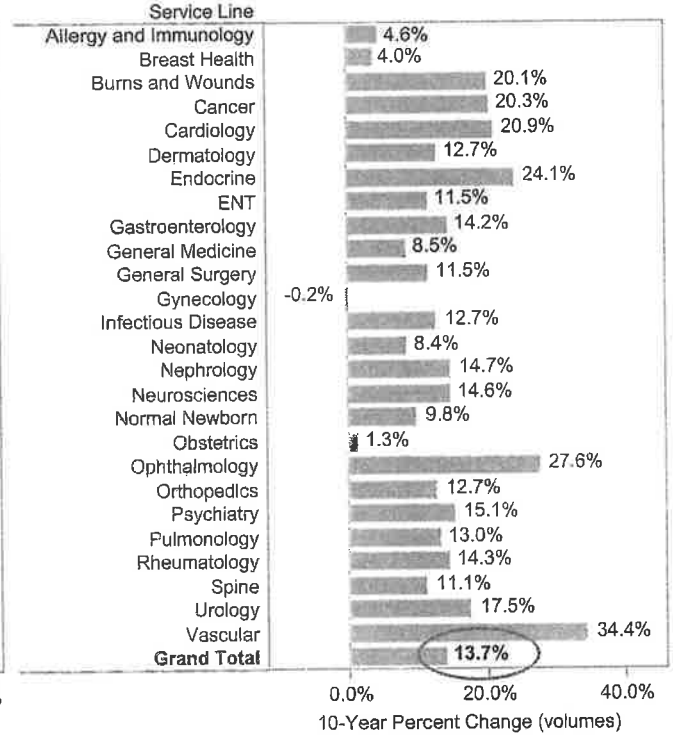
10-Year Cumulative % Change in Discharges by Service Line

Click on the Service Lines below to view Sg2's Expert Analysis



10-Year Cumulative % Change in Volumes by Service Line

Click on the Service Lines below to view Sg2's Expert Analysis



Service Lines are based on a rollup of Sg2 CARE Families.

SURGERY

Service Line Snapshot 2017

health care intelligence

Snapshot

SURGERY

LANDSCAPE

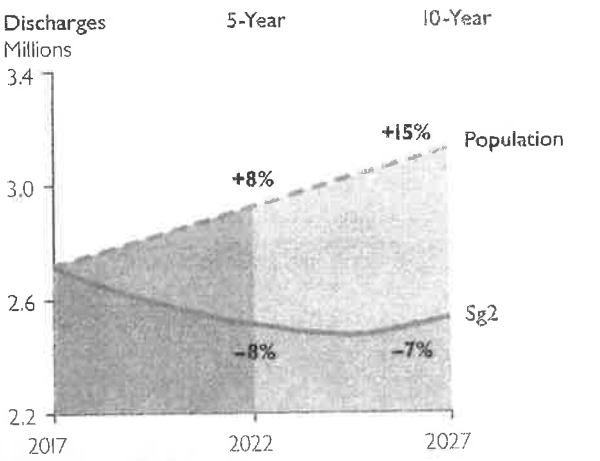
Surgical services remain a cornerstone for hospital margins—in 2017 surgeons will perform more than 50 million operations in the US. The shift from inpatient to outpatient venues continues to impact surgical growth strategy in the short-term. Multiple pressures provide momentum for this inexorable shift: nontraditional reimbursement models, active/passive steerage, narrow networks, consumerism, price transparency and the relocation to low-cost venues to optimize value-based care. This OP shift is tempered somewhat as high-complexity procedures and high-acuity patients are likely to remain in IP venues.

TOP TRENDS

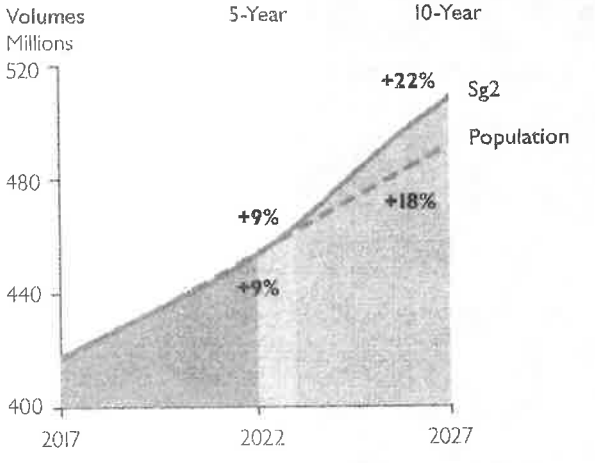
- Surgery OP volumes are expected to grow by 9% over the next 5 years compared with an 8% decline for IP discharges.
- The rate of IP decline begins to plateau in outlying years as the "floor" for IP activity is reached. Indeed, 2 surgical specialties have largely completed the crossover to OP venues—ENT and ophthalmology are now fundamentally OP specialties, with the exception of complex cancer cases.
- Urology continues a long-standing shift to the OP setting, driven by revised screening guidelines and new technologies.
- General surgery continues its outpatient transition. Currently, almost 66% of these procedures are performed in the OP setting. This rate will likely rise to almost 80% over the coming years.
  - Most hernia repairs, cholecystectomy appendectomies and breast surgeries (80% to 90%) are poised to be performed in OP sites, with the exception of procedures performed on patients with comorbid illnesses that require IP care.
- Medical therapy utilizing antibiotics has shown great value in the treatment of uncomplicated appendicitis. This trend mitigates the need for urgent or emergent surgery and drives an OP procedural shift.
- Virtual health becomes an increasingly important venue for both pre- and postsurgical care, particularly for burn and wound care.
- For donor organs, extended criteria for their acceptance and a significant increase in organs from deceased individuals due to drug overdose have stimulated donor supply and overall transplant volumes in the past 2 years. We expect that trend to continue for the short- to medium-term.

US MARKET FORECAST

Inpatient Surgery Forecast
2017–2027



Outpatient Surgery Forecast
2017–2027

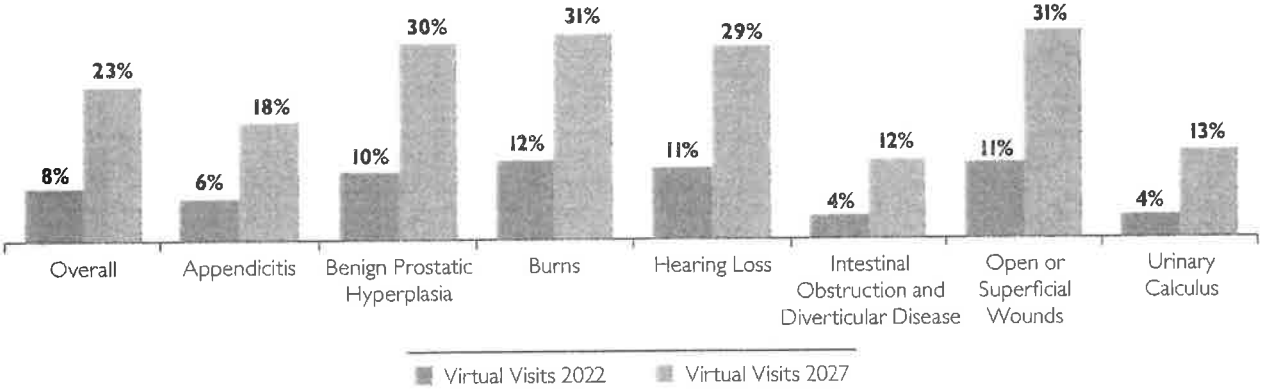


Note: Analysis excludes 0–17 age group. Surgery includes burns and wounds, ophthalmology, otolaryngology (ear, nose and throat [ENT]), general surgery and urology service lines. Procedures and CARE Families only include volumes from the surgery service line group. Sources: Impact of Change®, 2017; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2014. Agency for Healthcare Research and Quality, Rockville, MD; OptumInsight, 2015; The following 2015 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2017; Sg2 Analysis, 2017.

ACTION STEPS TO DRIVE VALUE

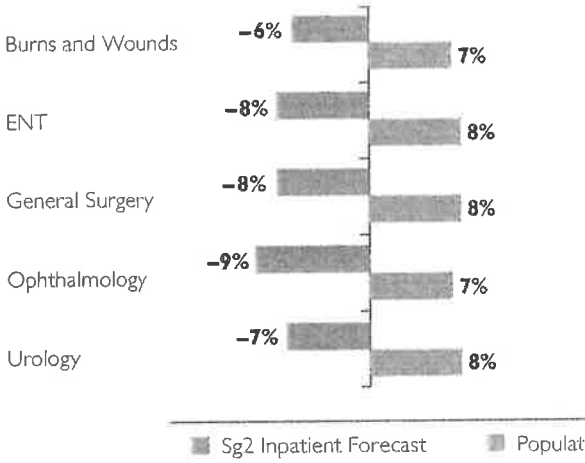
- Develop a workforce plan to address growing market demand and fluctuating surgical staff demographics. Advanced practitioners improve efficiency and fill clinical care gaps.
- Stay ahead of outpatient shift. Partner with providers and organizations to expand your surgical footprint beyond your hospital and across your System of CARE.
- Establish operational tactics to minimize cost and care variability, improve safety, foster enhanced recovery protocols and, where appropriate, rationalize care by partnering with higher-volume centers.
- Prepare for perioperative surgical home models, which continue to gain traction, to improve outcomes and satisfaction and to lower costs and clinical variation throughout the pre- and post-op surgical period.

Sg2 Forecast for Virtual Visits in Surgery, US Market, 2022 and 2027
Percent Penetration of E&M Visits by CARE Family

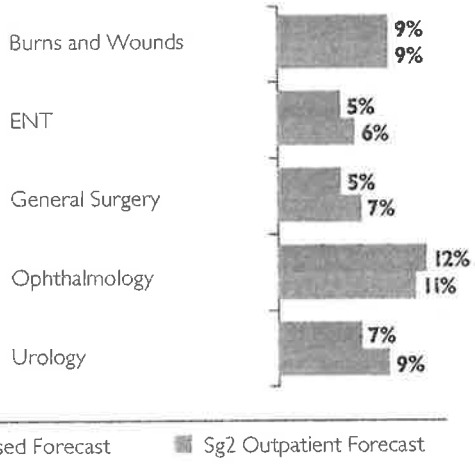


Note: Analysis excludes 0–17 age group. Percentage calculatation: number of virtual E&M visits ÷ total number of E&M visits (2017 total E&M visits used as baseline). Overall includes all CARE Families from the surgery service line group. E&M = evaluation and management. Sources: Impact of Change®, 2017; OptumInsight, 2015; The following 2015 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2017; Sg2 Analysis, 2017.

5-Year Inpatient Surgery Discharges by Service Line
2017–2022



5-Year Outpatient Surgery Volumes by Service Line
2017–2022



Sg2 Inpatient Forecast Population-Based Forecast Sg2 Outpatient Forecast

Note: Analysis excludes 0–17 age group. Sources: Impact of Change®, 2017; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2014. Agency for Healthcare Research and Quality, Rockville, MD; OptumInsight, 2015; The following 2015 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2017; Sg2 Analysis, 2017.

sg2 health care intelligence

Sg2 2017 Impact of Change Forecast: Finding Growth

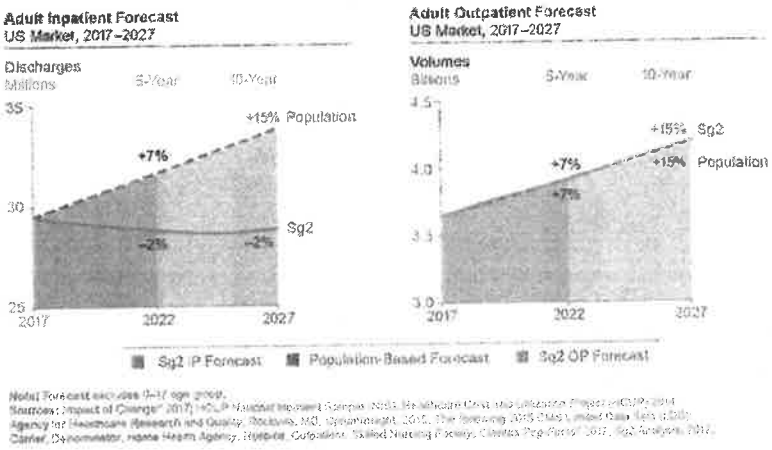
By: Madeleine McDowell, MD, FAAP Principal and Medical Director

April 26, 2017

Each year at Sg2, we debut the latest health care projections from our Impact of Change® (IoC) national demand forecast. Sg2 has a track record of forecasting inpatient declines that mirror actual volume trends. This year is no exception, but with some checks and balances, Sg2 projects the downward impact on inpatient utilization to begin to plateau, as rising complexity and a growing elderly population push the limits in opportunities for care to shift outpatient.

Over the next 10 years, Sg2 projects a 2% decline in adult IP discharges and 15% growth in OP volumes across the US. The downward impact on IP demand continues, largely due to the shift from volume to value and increased scrutiny of health care costs by government and payers. Sg2 projects an uptick in OP shift for surgeries traditionally performed in the IP setting, resulting in a 4% decline for IP surgical admissions, and an 11% increase in overall OP surgeries from 2017 to 2022.

Inpatient Declines Level Off, Outpatient Volumes Mirror Population Estimates



Note: Forecast excludes 0–17 age group.
Sources: Impact of Change® 2017 IoC® National Inpatient Sample; Note: Healthcare Cost and Utilization Project (HCUP), 2014; Agency for Healthcare Research and Quality, Rockville, MD, Department of HHS, 2016; The following CMS Limited Data Sets (LDS) Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility, Chronic Pop Files, 2017; Sg2 Analysis, 2017

Outpatient and Observation Shift Begins to Plateau

Though the shift to value continues, challenges exist in terms of case mix acuity and the rising aging population. While ongoing OP shift will continue to drive IP use rates down over the next 5 to 10 years, the shift to observation care will taper. Significant shift to observation status has already taken place for many medical conditions, resulting in a higher-acuity IP population. Rising IP case mix can be demonstrated by recent Healthcare Cost and Utilization Project (HCUP) average length of stay (ALOS) trends, showing a reversal in ALOS decline trends with a 2.5% increase from 2011 to 2014.* Sg2's observation forecast now tracks population growth, with 8% growth projected at 5 years.

With rising acuity in the IP setting, Sg2 predicts further increases in ALOS of 2% over the decade, which, when combined with the 2% decrease in IP discharges, will result in a 1% decline in overall adult IP days.

Three key areas of focus in Sg2's 2017 forecast are: 1) the dynamic changes in health care policy and coverage; 2) the shift to value; and 3) consumer-driven forces. All have significant impacts on utilization and site of care. For the moment, the pace of CMS's commitment to support the transition to value may have slowed, evidenced by the decision to delay all mandatory bundled payment programs. However, value initiatives such as commercial bundles and alternative payment contracting are attractive solutions to cost containment and will advance the transition to value. Policies with bipartisan support remain integral to this transition, such as the Quality Payment Program of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Medicare Advantage, and post-acute care site-neutral payment in the IMPACT Act. Increased consumerism, due to rising high-deductible health plans, alternative care options and financial transparency tools, further promotes the shift to value, as patients seek lower-cost services and sites of care.

New to the 2017 IoC!

The Impact of Change's success is based on its foundation in disease-based forecasting. ICD diagnosis and procedure codes and CPT codes are grouped into clinically meaningful CARE Families (diseases) and Procedures (services) in the Sg2 CARE Grouper for easy understanding of growth opportunities across the care continuum.

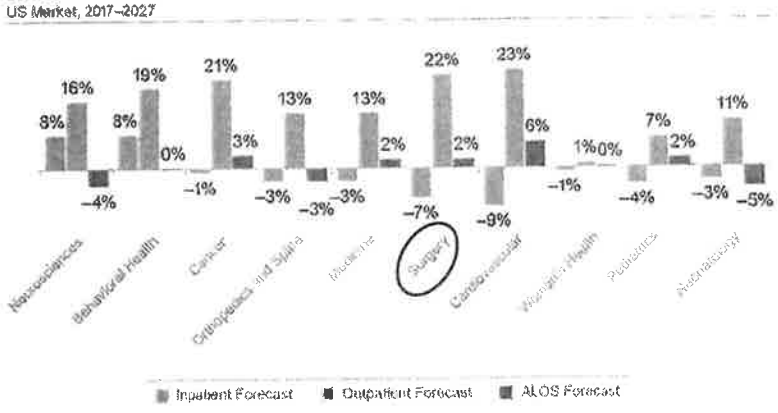
Each year, we update the Sg2 CARE Grouper to account for new and retired codes and carve out new Procedures or CARE Families. This year we added 10 new OP CARE Procedures, including Addiction Therapy, Laryngoscopy, Sinus Endoscopy, Cystoscopy and Primary Shoulder Replacement (for a complete list of additions, see Sg2 Update for 2017 CARE Grouper attachment). These additional procedures allow for line of sight into utilization and growth opportunities for these services.

Surgery is its own Service Line Group. We restructured our Service Line Groups to separate medicine from surgery so they now fall into 2 distinct Service Line Groups. The new taxonomy is consistent with the vast majority of health systems' departmental structures in terms of which service lines are traditionally placed under surgery vs medicine. This change essentially involved mapping the existing Service Lines to either Medicine or Surgery Service Line Groups. (See Sg2 Update for 2017 CARE Grouper addendum for detailed description and 2017 mappings.)

Impact factors are simplified. We have updated our impact factors to reflect the changing times, rolling the IP Sg2 Potentially Avoidable Admission Impact Factor into Systems of CARE and rolling the 30-Day Readmissions Impact Factor into Policy. There will now be 6 matching impact factors for the IP and OP forecast: Population, Epidemiology, Systems of CARE, Innovation/Technology, Policy, and Economy and Consumerism.

Utilization Trends Vary Significantly by Service Line

Service Line Growth Rates
US Market, 2017–2027



Note: Cardiovascular includes cardiology and vascular service lines. Medicine includes allergy and immunology, dermatology, endocrinology, gastroenterology, general medicine, infectious disease, nephrology, pulmonology, and rheumatology service lines. Surgery includes burns and wounds, general surgery, ophthalmology, ENT, and urology service lines. Neurosciences includes the Brain Cancer CARE Keyed. Behavioral health includes the psychiatry service line group. Sources: Impact of Change®, 2017; HCUP National Inpatient Sample (NIS); Healthcare Cost and Utilization Project (HCUP), 2014; Agency for Healthcare Research and Quality, Rockville, MD; Optum Insight, 2015; The following 2015 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claims Snapshot®, 2017; Sg2 Analysis, 2017.

Key IP and OP service line forecast stories follow:

- **Ortho/spine:** Inpatient declines are projected (–3% overall in 10 years). Osteoarthritis discharges comprise nearly 50% of all orthopedic discharges; these volumes are projected to decline 5% in the next 5 years, largely due to OP shift in primary joint replacement. Outpatient shift for many spine surgeries, including spine fusions, also will accelerate. As these surgeries shift OP and overall demand increases, expect ortho/spine surgical growth to soar by 35% during the same time period.**
  - Pockets of IP growth remain. For example, IP growth in revision joint replacements is projected at 21% in 5 years and 55% in 10 years (with no OP shift).
  - Capitalizing on high growth projections for OP ortho and spine surgeries will require understanding who owns these services. Consumer-driven care choices dominate the OP landscape for ortho/spine, dampening growth for rehab follow-up visits and shifting care away from the ED and hospital.
- **Cardiovascular:** The significant IP declines in medical **cardiology** due to shift to observation will continue, but at a slower pace, as rising complexity and an aging population push the limits of future observation and OP shift. Technology advances and payment incentives continue to shift interventional cardiology and electrophysiology procedures OP, contributing to overall IP cardiology declines. At the same time, coronary artery bypass graft (CABG) and heart valve surgeries† will grow 13% and 27%, respectively, over the decade as expanded indications for these high-volume IP surgeries drive applications to new patient populations. Technology advances in transcatheter valve replacement will be a main driver of overall valve surgery growth, as applications for this procedure expand to lower-risk populations and mitral valve conditions.
- **Neurosciences:** Inpatient growth projections continue, largely due to improved triage, increased demand for advanced stroke care, and expanded applications for diagnostics and treatment of epilepsy.
- **Women's Health:** Inpatient gynecology declines sharpen by –28% over 10 years, with accelerated OP shift for hysterectomy and limited IP growth for pelvic floor procedures. In obstetrics, birth rates are expected to remain flat, as immigration remains low and small family size becomes a cultural norm. At the same time, c-section rates will continue to decline as adoption of OB delivery guidelines and payer incentives to reduce primary c-sections roll out. Nationally, Sg2 is projecting the c-section rate decline to reach a floor of 26% of all live births in 10 years.
- **Neonatology:** Projected declines have been tapered as we see early evidence of a leveling in preterm birth (PTB) rates following 8 consecutive years of annual decline. Further gains in PTB reductions will require clinical innovation as well as value-based payment incentives that support investment in high-risk PTB prevention programs. These are unlikely to take hold until the end of the decade.
- **Cancer:** Advances in molecular diagnostics, immunotherapy and targeted treatment regimens will continue to erode IP medical oncology volumes, with admissions for "no procedure" expected to decline 23% over the decade. However, overall IP cancer declines will be mitigated by growth in surgery, as improved screening and diagnostics allow for earlier detection of cancer, expanding the pool of surgical candidates.
- **Surgery:** Inpatient declines are projected for Sg2's new Service Line Group (comprised of Burns and Wounds, ENT, Urology, General Surgery and Ophthalmology Service Lines), as OP shift for general surgery and urology procedures continues, driven by clinical innovation and payer pressures.

For a deeper dive into the forecasts for all of the service lines, check out the 10 webinars that are part of our ongoing 2017 Service Line Landscape Series. (See links below in Sg2 Resources.) Each webinar drills into the IoC forecast by service line and outlines key drivers of change.

*HCUP data showed a 2.5% increase in ALOS for the adult population excluding OB, a 1.7% increase in ALOS for the adult population including OB, and a 1.9% increase in ALOS for all ages and all discharges from 2011 to 2014. **Ortho/spine OP surgeries are defined as Major Procedures and Arthroscopy for Ortho/Spine Service Lines for the adult population. †Heart valve surgeries are defined in the Sg2 CARE Grouper as the combination of the following Sg2 Procedures: Surgical Valve Procedure and Transcatheter Valve Procedure.

Sources: Impact of Change® v17.0; NIS; Optum; CMS; Healthcare Cost and Utilization Project, 2016; Sg2 Analysis, 2017.

Sg2 Resources

Sg2 Webinars (All upcoming webinars are held at noon CT):

- 2017 Impact of Change Update: On-Demand
- Orthopedics Landscape: On-Demand
- Neurosciences Landscape: May 3
- Cardiovascular Landscape: May 10
- Spine Landscape: May 17
- Pediatrics Landscape: May 24
- Behavioral Health Landscape: May 31
- Women's Health Landscape: June 14

- Cancer Landscape: June 21
- Surgery Landscape: June 28
- Medicine Landscape: July 5

Attachments

- Sg2 Expert Insight: 2017 Impact of Change Forecast: Finding Growth (PDF)
- Sg2 Update for 2017 CARE Grouper (PDF)

847.779.5300

ORTHOPEDICS

Service Line Snapshot 2017

health care intelligence

Service Line Snapshot

ORTHOPEDICS

SERVICE LINE LANDSCAPE

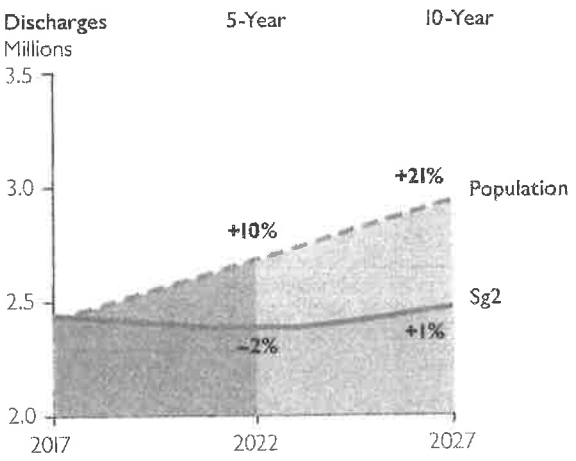
An aging US population will drive increased demand for orthopedics services over the next decade. Inpatient growth continues to slow as total joint replacement (TJR) procedures shift to less costly hospital outpatient departments and ambulatory surgery centers (ASCs). Provider innovation in the creation and delivery of bundled payments addresses payer and consumer demands for cost certainty and improved value. Organizations redesign their Systems of CARE with specific attention to presurgical patient optimization and reduced utilization in the post-acute setting. Rehabilitation and urgent care centers evolve to create new referral channels and lower-cost entry points for price-sensitive consumers. Hospitals insulate themselves from slowing inpatient TJR volumes by leveraging expertise in sports medicine, fragility fractures and rehabilitation. Consolidation of independent orthopedic surgeon practices inspires innovative provider alliances.

TOP TRENDS

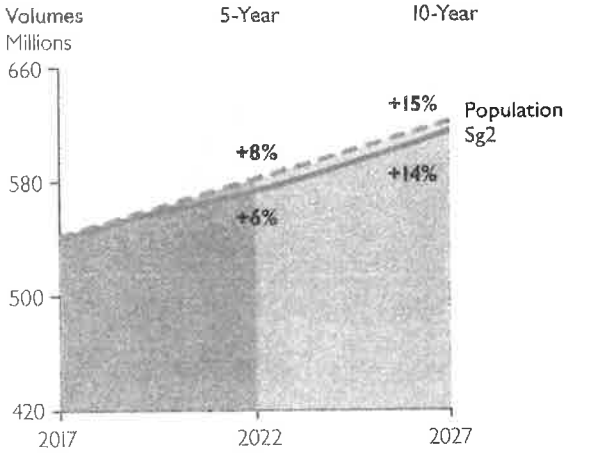
- A significant outpatient shift accelerates for TJR procedures. The pace of change varies widely by region and is driven primarily by surgeon preference and consumer demand.
- Sports medicine volumes grow, with initiatives evolving to satisfy an active adult population.
- Coordination with OP rehab becomes increasingly important as a referral channel and an outlet for less costly post-acute care.
- Better management of osteoporosis and fall risk reduces the number of fragility fractures and drives outpatient growth.
- As healthier commercially insured patients shift their surgeries to ambulatory settings, operating room efficiency and cost-reduction initiatives gain significance.
- Early-stage bundled payment initiatives lead to extensive growth of episode-based contracting with commercial payers and employers for a variety of orthopedic episodes.
- Value-based reimbursement prompts a narrowing of networks and care pathway refinements in the post-acute setting.
- As traditional comanagement agreements achieve desired efficiencies, physician alignment strategies evolve to include innovative value-based alignment models and joint venture strategies.
- EMR system refinements and increased utilization of outcomes registries enhance opportunities to benchmark performance and streamline Systems of CARE.
- Orthopedic urgent care centers expand outreach to orthopedic consumers and enhance access.

US MARKET FORECAST

Inpatient Orthopedics Forecast
2017–2027



Outpatient Orthopedics Forecast
2017–2027

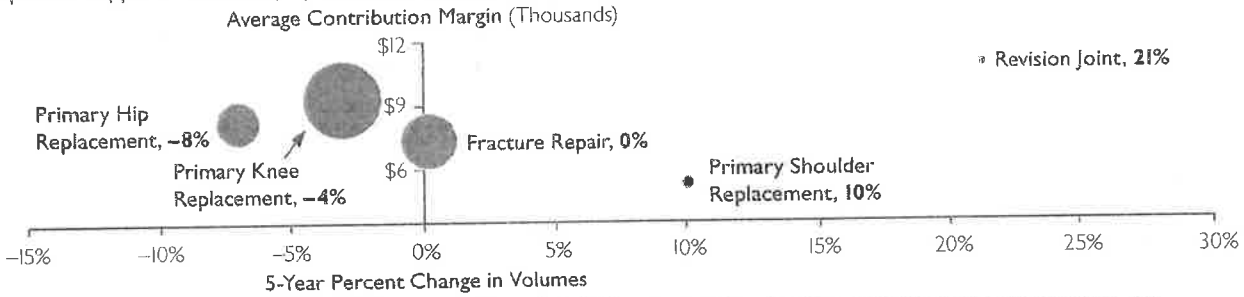


Note: Analysis excludes 0–17 age group. Sources: Impact of Change®, 2017; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2014. Agency for Healthcare Research and Quality, Rockville, MD; Optuminsight, 2015; The following 2015 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2017; Sg2 Analysis, 2017.

ACTION STEPS TO DRIVE VALUE

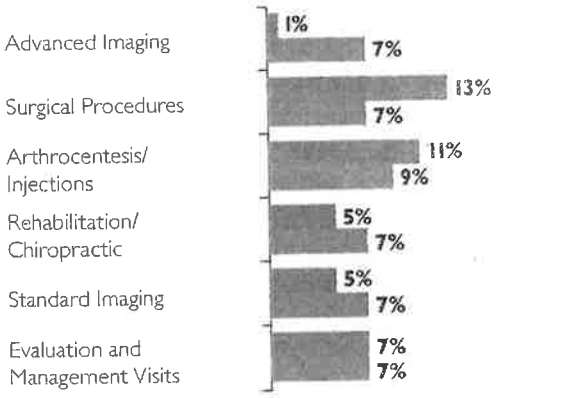
- Defend and grow surgical market share by proactively managing the transition of inpatient procedures to your outpatient departments and ASCs.
- Enhance your commitment to OP rehab and urgent care to solidify referral channels for musculoskeletal services.
- Explore bundled payments for orthopedic procedures such as TJR, rotator cuff repair and ACL reconstruction.
- Engage patients and their families through the use of care coordinators, preoperative education and virtual technologies to manage expectations and improve compliance.
- Create narrow post-acute networks that emphasize the delivery of high-quality and less costly care.
- Leverage subspecialties that target marketplace niches, including sports medicine and fragility fracture programs.
- Evaluate the impact of investment in robotic technologies.
- Consider co-location of multispecialty providers to increase alignment and foster consumer awareness.
- Collect and monitor longitudinal data through patient-reported outcomes and joint registry enrollment.

Inpatient Opportunities Vary by Procedure Type, US Market, 2017–2022

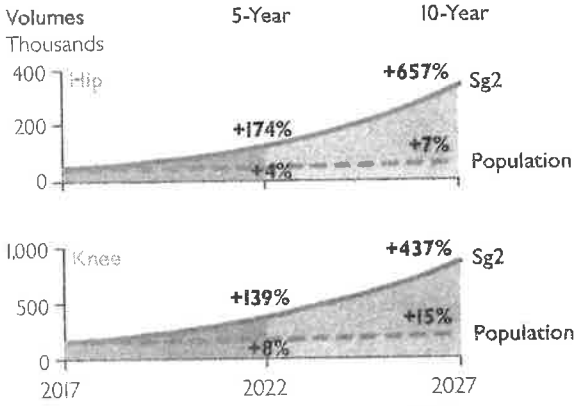


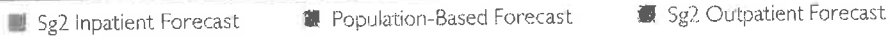
Note: Financial data for Large Community Hospital Peer Group. Analysis excludes 0–17 age group and includes select orthopedic procedures. The size of the bubble represents the procedure's proportion of overall inpatient orthopedic procedure volumes. ACL = anterior cruciate ligament. **Sources:** Sg2 Comparative Database, 2017; Impact of Change®, 2017; HCUP National Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP) 2014. Agency for Healthcare Research and Quality, Rockville, MD; Claritas Pop-Facts®, 2017; Sg2 Analysis, 2017.

5-Year Outpatient Orthopedics Volumes by Procedure and Visit Type, 2017–2022



10-Year Outpatient Hip/Knee Replacement Forecast 2017–2027





Note: Analysis excludes 0–17 age group. Surgical procedures include endoscopy and major procedures. Advanced imaging includes CT, MRI and positron emission tomography. Standard imaging includes nuclear medicine/single-photon emission computed tomography, ultrasound and x-ray. OP hip and knee replacement forecasts include primary hip/knee replacement major procedure and the Osteoarthritis CARE Family. **Sources:** Impact of Change®, 2017; OptumInsight, 2015; The following 2015 CMS Limited Data Sets (LDS): Carrier, Denominator, Home Health Agency, Hospice, Outpatient, Skilled Nursing Facility; Claritas Pop-Facts®, 2017; Sg2 Analysis, 2017.

Anticipate the Impact of Change

Sg2, a Vizient company, is the health care industry's premier authority on health care trends, insights and market analytics.

Our analytics and expertise help hospitals and health systems achieve sustainable growth and ensure ongoing market relevance through the development of an effective System of CARE.

5250 Old Orchard Road, Skokie, IL 60077 | 847.779.5300 | Sg2.com
MK-649-E-0517

Sg2
health care intelligence

TriStar StoneCrest Medical Center

Smyrna, TN

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

April 15, 2016

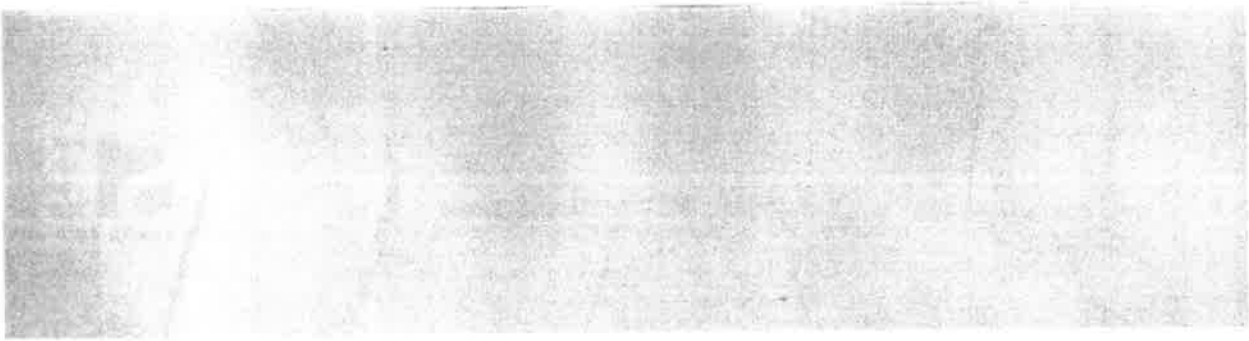
Accreditation is customarily valid for up to 36 months.

Rebecca J. Patchin, MD
Chair, Board of Commissioners

ID #384322
Print/Reprint Date: 06/20/2016

Mark R. Chassin, MD, FACP, MPP, MPH
President

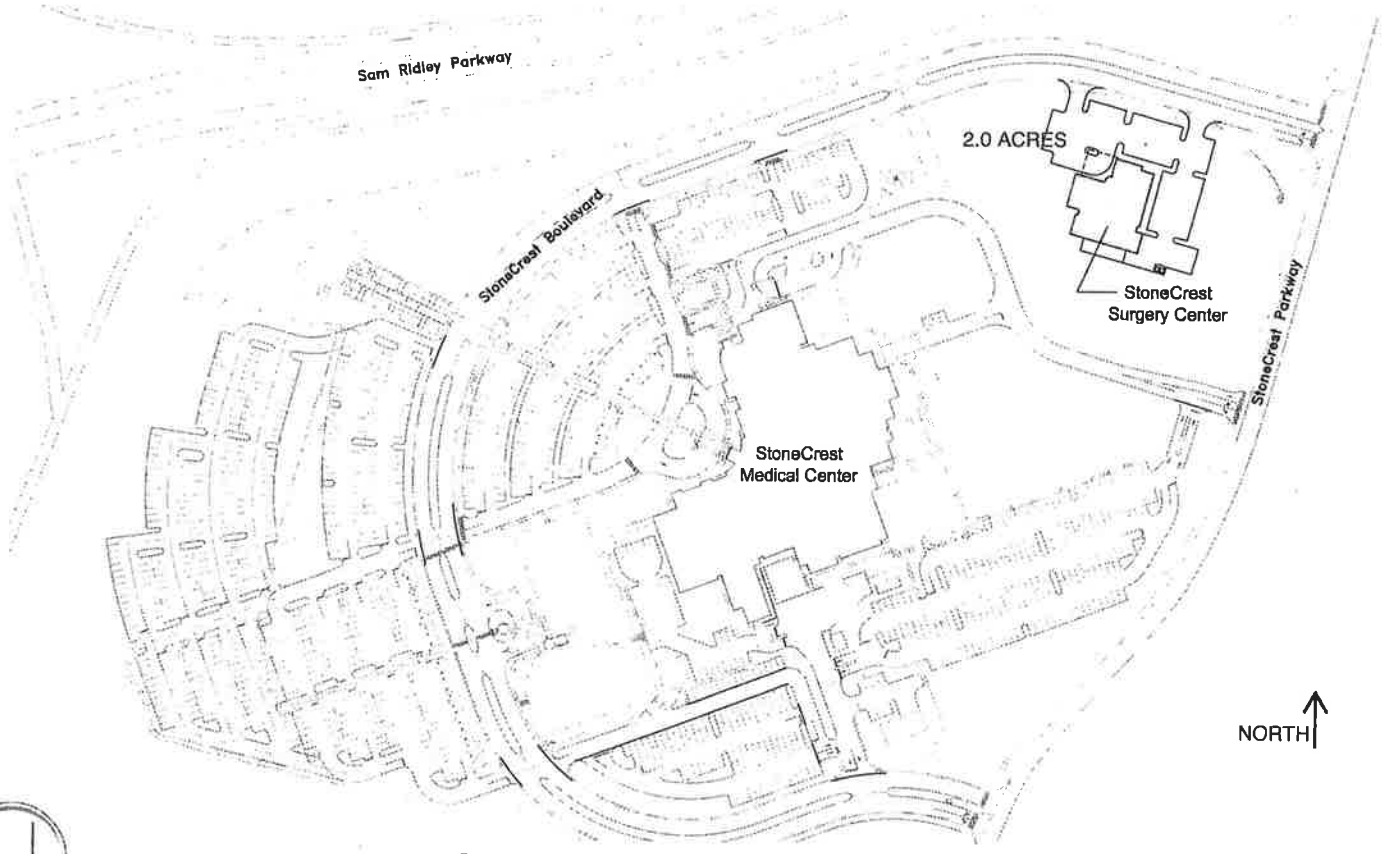
The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.



A-6B(1)a-d

Plot Plan

SUPPLEMENTAL #1
July 31, 2017
8:27 am



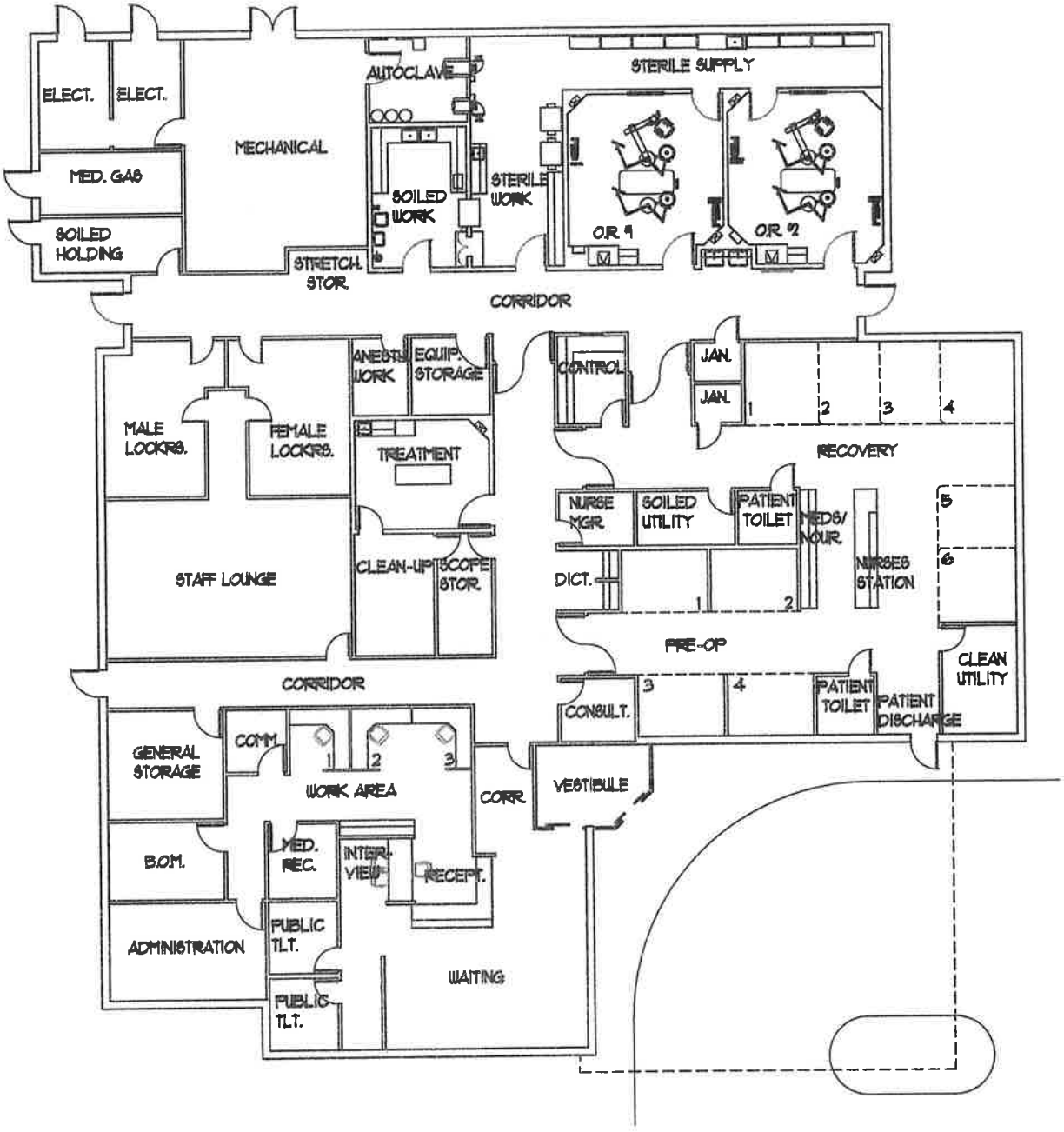
StoneCrest Surgery Center

Site Plan

HCA

A-6B(2)

Floor Plans



StoneCrest Surgery Center

Floor Plan

HCA

HEREFORD·DOOLEY
ARCHITECTS

William E. Hereford, III Principal
Thomas Dooley Senior Principal

HEREFORD·DOOLEY
ARCHITECTS

July 24, 2017

StoneCrest Surgery Center - Space Allocation

Vestibule	145
Waiting	655
Receptionist	126
Interview	63
Communications	64
Medical Records	84
Public Toilet	81
Public Toilet	81
Work Area	462
General Storage	209
B.O.M.	149
Administration	254
Consultation	80
Nurses Sta./Med./Nour.	154
Recovery	1170
Recovery Tlt.	52
Pre-Op	794
Pre-Op Tlt.	57
Clean Utility	135
Soiled Utility	86
Nurse Manager	68

William E. Hereford, III Principal
Thomas Dooley Senior Principal

HEREFORD·DOOLEY
ARCHITECTS

Dictation	63
Staff Lounge	717
Male Lkr./Tlt.	271
Women Lkr./Tlt.	277
Scope Storage	111
Clean – Up	155
Treatment	220
Jan. #1	29
Jan. #2	29
Control	101
Equip. Storage	100
Anesthesia Work	69
O.R. #1	404
O.R. #2	405
Sterile Supply	373
Sterile Work	272
Soiled Work	217
Autoclave	136
Mechanical	672
Soiled Holding	127
Medical Gas	144
Electrical #1	123
Electrical #2	123

William E. Hereford, III Principal
Thomas Dooley Senior Principal

HEREFORD·DOOLEY
ARCHITECTS

Square Footage Subtotal:	10,107 SF
Circulation/Structure:	2,883 SF
Gross Total:	12,990 SF

A-6B(3)

Description of Accessibility

ACCESSIBILITY TO STONECREST SURGERY CENTER SITE

The StoneCrest Medical Center campus is within sight of I-24 at Exit 66 in Smyrna in North Rutherford County. It is on the south side of Sam Ridley Parkway, just east of the interstate. The StoneCrest Surgery Center will be on the hospital campus in an easily visible location east of existing campus buildings.

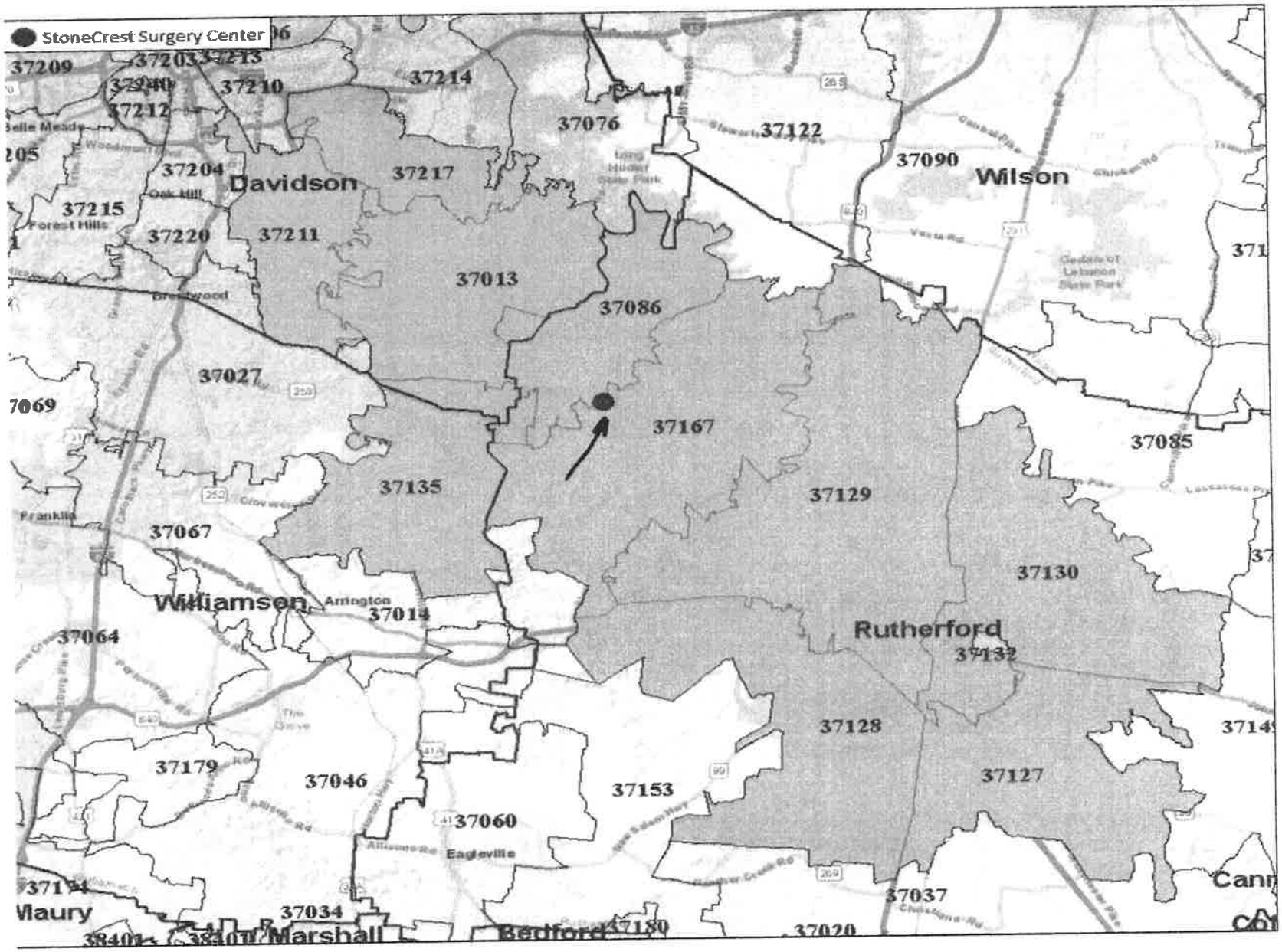
I-24 and Sam Ridley Parkway, and numerous other roadways in the service area, will provide StoneCrest Surgery Center patients with access to all parts of its surgical service area.

There is currently no public transportation at the site; patients use automobiles and EMS vehicles for transport to and from the hospital, for both elective and emergency care.

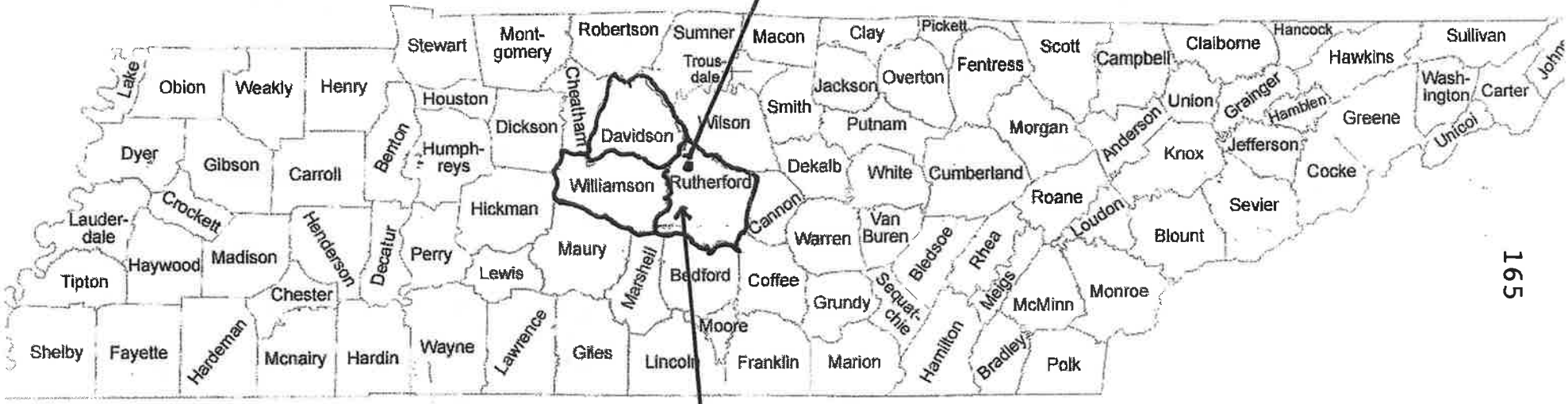
B-Need-3

Service Area Map

StoneCrest Surgery Center Primary Service Area



STONECREST SURGERY CENTER



COUNTIES CONTAINING ITS PRIMARY SERVICE AREA

B-Economic Feasibility-1E

Documentation of Construction Cost Estimate

William E. Hereford, III Principal
Thomas Dooley Senior Principal

HEREFORD·DOOLEY
ARCHITECTS

July 24, 2017

Melanie M. Hill, Executive Director
Tennessee Health Services and Development Agency
500 Deaderick Street
Nashville, Tennessee 37243

Re: StoneCrest Surgery Center, Smyrna

Dear Ms. Hill,

Hereford Dooley Architects, Inc., an architectural firm registered to practice in Tennessee, has reviewed the cost data provided for the above referenced facility. The stated construction cost for this construction is $6,181,500 at $225 PSF for the building shell and $250 PSF for the tenants build out. It is our opinion that the proposed construction cost appears to be reasonable for this project type and size.

This is a summary of the current building codes enforced for this project:

State of Tennessee Division of Health Care Facilities:
2012 International Building Code with Local Amendments
2012 International Energy Conservation Code
2009 ICC/ANSI A-117.1 Accessible and Usable Buildings and Facilities
2012 International Plumbing Code with Local Amendments
2012 International Mechanical Code with Local Amendments
2012 International Fuel Gas Code with Local Amendments
2011 National Electrical Code with Local Amendments
2012 International Fire Code with Local Amendments
2012 Life Safety Code (NFPA 101) with Local Amendments

If you have any questions regarding this matter, please feel free to call me.

Respectfully,

Thomas A. Dooley AIA
tom.dooley@hdarchitects.com
Senior Principal

B-Economic Feasibility--2

Documentation of Funding/Financing Availability

TriStar Health

TriStarHealth.com
110 Winners Circle, First Floor
Brentwood, TN 37027
(615) 886-4900

July 23, 2017

Melanie Hill, Executive Director
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: StoneCrest Surgery Center

Dear Mrs. Hill:

StoneCrest Surgery Center, LLC is filing an application to establish the subject facility on the campus of TriStar StoneCrest Medical Center in Smyrna, which is part of the TriStar Health system. Our system's hospitals are owned by HCA Healthcare, Inc., through wholly owned subsidiaries.

Currently, HCA Healthcare, Inc. is also the ultimate parent company for the CON applicant. If CON approval is granted, the applicant hopes to syndicate a portion of its interests to medical staff of the surgery center, to share in the project cost.

The estimated total capital expenditure needed to implement this project is $9,685,553. As Chief Financial Officer of TriStar Health, the HCA Division Office for Middle Tennessee, I am writing to confirm that HCA Healthcare, Inc. is committed to provide through TriStar Health up to this full amount of funding. HCA Healthcare, Inc.'s financial statements are provided in the application.

Sincerely,

C. Eric Lawson
Chief Financial Officer
Tristar Health

B-Economic Feasibility-6A

Applicant's Financial Statements

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)
☒ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the fiscal year ended December 31, 2015
Or
☐ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to
Commission File Number 1-11239

HCA Holdings, Inc.

(Exact Name of Registrant as Specified in its Charter)

Delaware	27-3865930
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)
One Park Plaza Nashville, Tennessee	37203
(Address of Principal Executive Offices)	(Zip Code)

Registrant's telephone number, including area code: (615) 344-9551

Securities Registered Pursuant to Section 12(b) of the Act:

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, $0.01 Par Value	New York Stock Exchange

Securities Registered Pursuant to Section 12(g) of the Act: None

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the Registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the Registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the Registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the Registrant was required to submit and post such files). Yes ☒ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of Registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the Registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐ (Do not check if a smaller reporting company)	Smaller reporting company	☐

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of January 31, 2016, there were 396,958,400 outstanding shares of the Registrant's common stock. As of June 30, 2015, the aggregate market value of the common stock held by nonaffiliates was approximately $29.839 billion. For purposes of the foregoing calculation only, Hercules Holding II, LLC and the Registrant's directors and executive officers have been deemed to be affiliates.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's definitive proxy materials for its 2016 Annual Meeting of Stockholders are incorporated by reference into Part III hereof.

HCA HOLDINGS, INC.
CONSOLIDATED INCOME STATEMENTS
FOR THE YEARS ENDED DECEMBER 31, 2015, 2014 AND 2013
(Dollars in millions, except per share amounts)

	2015	2014	2013
Revenues before the provision for doubtful accounts	$ 43,591	$ 40,087	$ 38,040
Provision for doubtful accounts	3,913	3,169	3,858
Revenues	39,678	36,918	34,182
Salaries and benefits	18,115	16,641	15,646
Supplies	6,638	6,262	5,970
Other operating expenses	7,103	6,755	6,237
Electronic health record incentive income	(47)	(125)	(216)
Equity in earnings of affiliates	(46)	(43)	(29)
Depreciation and amortization	1,904	1,820	1,753
Interest expense	1,665	1,743	1,848
Losses (gains) on sales of facilities	5	(29)	10
Losses on retirement of debt	135	335	17
Legal claim costs	249	78	—
	35,721	33,437	31,236
Income before income taxes	3,957	3,481	2,946
Provision for income taxes	1,261	1,108	950
Net income	2,696	2,373	1,996
Net income attributable to noncontrolling interests	567	498	440
Net income attributable to HCA Holdings, Inc.	$ 2,129	$ 1,875	$ 1,556
Per share data:			
Basic earnings per share	$ 5.14	$ 4.30	$ 3.50
Diluted earnings per share	$ 4.99	$ 4.16	$ 3.37
Shares used in earnings per share calculations (in millions):			
Basic	414.193	435.668	445.066
Diluted	426.721	450.352	461.913

The accompanying notes are an integral part of the consolidated financial statements.

Table of Contents

HCA HOLDINGS, INC.
CONSOLIDATED COMPREHENSIVE INCOME STATEMENTS
FOR THE YEARS ENDED DECEMBER 31, 2015, 2014 AND 2013
(Dollars in millions)

	2015	2014	2013
Net income	$2,696	$2,373	$1,996
Other comprehensive income (loss) before taxes:			
Foreign currency translation	(63)	(74)	18
Unrealized gains (losses) on available-for-sale securities	1	9	(7)
Defined benefit plans			
Pension costs included in salaries and benefits	30	(158)	134
	32	21	38
	62	(137)	172
Change in fair value of derivative financial instruments	(36)	(36)	3
Interest costs included in interest expense	125	132	131
	89	96	134
Other comprehensive income (loss) before taxes	89	(106)	317
Income taxes (benefits) related to other comprehensive income items	31	(40)	117
Other comprehensive income (loss)	58	(66)	200
Comprehensive income	2,754	2,307	2,196
Comprehensive income attributable to noncontrolling interests	567	498	440
Comprehensive income attributable to HCA Holdings, Inc.	$2,187	$1,809	$1,756

The accompanying notes are an integral part of the consolidated financial statements.

HCA HOLDINGS, INC.
CONSOLIDATED BALANCE SHEETS
DECEMBER 31, 2015 AND 2014
(Dollars in millions)

	2015	2014
ASSETS		
Current assets:		
Cash and cash equivalents	$ 741	$ 566
Accounts receivable, less allowance for doubtful accounts of $5,326 and $5,011	5,889	5,694
Inventories	1,439	1,279
Deferred income taxes	—	366
Other	1,163	1,025
	9,232	8,930
Property and equipment, at cost:		
Land	1,524	1,524
Buildings	12,533	11,941
Equipment	19,335	18,496
Construction in progress	1,222	1,019
	34,614	32,980
Accumulated depreciation	(19,600)	(18,625)
	15,014	14,355
Investments of insurance subsidiaries	432	494
Investments in and advances to affiliates	178	165
Goodwill and other intangible assets	6,731	6,416
Other	1,157	620
	$ 32,744	$ 30,980
LIABILITIES AND STOCKHOLDERS' DEFICIT		
Current liabilities:		
Accounts payable	$ 2,170	$ 2,035
Accrued salaries	1,233	1,370
Other accrued expenses	1,880	1,737
Long-term debt due within one year	233	338
	5,516	5,480
Long-term debt, less net debt issuance costs of $167 and $219	30,255	29,088
Professional liability risks	1,115	1,078
Income taxes and other liabilities	1,904	1,832
Stockholders' deficit:		
Common stock $0.01 par; authorized 1,800,000,000 shares; outstanding 398,738,700 shares — 2015 and 420,477,900 shares — 2014	4	4
Accumulated other comprehensive loss	(265)	(323)
Retained deficit	(7,338)	(7,575)
Stockholders' deficit attributable to HCA Holdings, Inc.	(7,599)	(7,894)
Noncontrolling interests	1,553	1,396
	(6,046)	(6,498)
	$ 32,744	$ 30,980

The accompanying notes are an integral part of the consolidated financial statements.

Proof of Publication

Public Notices

Public Notices

0002284978

NOTIFICATION OF INTENT TO APPLY FOR A CERTIFICATE OF NEED

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. Sections 68-11-1601 et seq., and the Rules of the Health Services and Development Agency, that StoneCrest Surgery Center (a proposed ambulatory surgical treatment center), to be owned by StoneCrest Surgery Center, LLC (a limited liability company), and to be managed by Medical Care America, LLC, intends to file an application for a Certificate of Need to establish a multispecialty ambulatory surgical treatment center with two operating rooms and one procedure room, at an unaddressed site within the campus of StoneCrest Medical Center, a hospital whose address is 200 StoneCrest Boulevard, Smyrna, TN 37167. The project will be located on land at the intersection of StoneCrest Boulevard and Stonecrest Parkway, east of existing hospital campus buildings.

The project cost is estimated at $11,000,000, including the value of the land and building that will be leased to the applicant. The facility will seek licensure as an Ambulatory Surgical Treatment Center, from the Board for Licensing Health Care Facilities. The project will not contain major medical equipment and will not affect any licensed bed complements.

The anticipated date of filing the application is on or before July 25, 2017. The contact person for the project is John Wellborn, who may be reached at Development Support Group, 4219 Hillsboro Road, Suite 210, Nashville, TN 37215; (615) 665-2022.

Upon written request by interested parties, a local Fact-Finding public hearing shall be conducted. Written requests for hearing should be sent to:

Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

Pursuant to TCA Sec. 68-11-1607(c)(1): '(A) any health care institution wishing to oppose a Certificate of Need application must file a written objection with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled, and (B) any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

DAILY CRYPTO... puzzle, but using numbers

Virgo above you: Your lucky numbers are 8, 2, 22, 28 and 45.

3 1 4 8 7 6 5 9 2

B-Orderly Development-4B

TDOH and Joint Commission Findings and Corrections

Official Accreditation Report

TriStar StoneCrest Medical Center
200 StoneCrest Boulevard
Smyrna, TN 37167

Organization Identification Number: 384322

Unannounced Full Event: 4/12/2016 - 4/14/2016

Report Contents

Executive Summary

Requirements for Improvement

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Opportunities for Improvement

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Plan for Improvement

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Executive Summary

Program(s)
Hospital Accreditation

Survey Date(s)
04/12/2016-04/14/2016

Hospital Accreditation : As a result of the accreditation activity conducted on the above date(s), Requirements for Improvement have been identified in your report.

You will have follow-up in the area(s) indicated below:

- Evidence of Standards Compliance (ESC)

If you have any questions, please do not hesitate to contact your Account Executive.

Thank you for collaborating with The Joint Commission to improve the safety and quality of care provided to patients.

Requirements for Improvement – Summary

Observations noted within the Requirements for Improvement (RFI) section require follow up through the Evidence of Standards Compliance (ESC) process. The timeframe assigned for completion is due in either 45 or 60 days, depending upon whether the observation was noted within a direct or indirect impact standard. The identified timeframes of submission for each observation are found within the Requirements for Improvement Summary portion of the final onsite survey report. If a follow-up survey is required, the unannounced visit will focus on the requirements for improvement although other areas, if observed, could still become findings. The time frame for performing the unannounced follow-up visit is dependent on the scope and severity of the issues identified within the Requirements for Improvement.

Evidence of DIRECT Impact Standards Compliance is due within 45 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	LS.02.01.20	EP1
	PC.01.02.08	EP2
	PC.01.03.01	EP26
	PC.03.05.09	EP2
	PC.03.05.11	EP1
	RC.02.01.01	EP2

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

Program:	Hospital Accreditation Program	
Standards:	EC.02.03.05	EP2,EP12
	EC.02.06.01	EP1
	LD.04.01.05	EP4
	LS.02.01.10	EP4,EP9
	LS.02.01.30	EP23
	LS.02.01.34	EP4
	LS.02.01.35	EP5,EP6,EP14
	MS.01.01.01	EP5
	MS.05.01.01	EP2

Evidence of INDIRECT Impact Standards Compliance is due within 60 days from the day the survey report was originally posted to your organization's extranet site:

RC.01.01.01	EP19

The Joint Commission
Summary of CMS Findings

CoP: §482.13 **Tag:** A-0115 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.13 Condition of Participation: Patient's Rights

A hospital must protect and promote each patient's rights.

CoP Standard	Tag	Corresponds to	Deficiency
§482.13(e)(11)	A-0176	HAP - PC.03.05.09/EP2	Standard
§482.13(e)(12)(i)(A)	A-0178	HAP - PC.03.05.11/EP1	Standard

CoP: §482.24 **Tag:** A-0431 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.24 Condition of Participation: Medical Record Services

The hospital must have a medical record service that has administrative responsibility for medical records. A medical record must be maintained for every individual evaluated or treated in the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.24(c)(1)	A-0450	HAP - RC.01.01.01/EP19	Standard
§482.24(c)(2)	A-0450	HAP - RC.01.01.01/EP19	Standard
§482.24(c)(4)(iii)	A-0464	HAP - RC.02.01.01/EP2	Standard

CoP: §482.41 **Tag:** A-0700 **Deficiency:** Standard

Corresponds to: HAP

Text: §482.41 Condition of Participation: Physical Environment

The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community.

CoP Standard	Tag	Corresponds to	Deficiency
§482.41(a)	A-0701	HAP - EC.02.06.01/EP1	Standard
§482.41(c)(2)	A-0724	HAP - EC.02.03.05/EP2, EP12	Standard
§482.41(b)(1)(i)	A-0710	HAP - LS.02.01.10/EP4, EP9, LS.02.01.20/EP1, LS.02.01.30/EP23, LS.02.01.34/EP4, LS.02.01.35/EP5, EP6, EP14	Standard

---

CoP: §482.22 **Tag:** A-0338 **Deficiency:** Standard

Corresponds to: HAP

The Joint Commission
Summary of CMS Findings

Text: §482.22 Condition of Participation: Medical staff

The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital.

CoP Standard	Tag	Corresponds to	Deficiency
§482.22(c)	A-0353	HAP - MS.01.01.01/EP5	Standard

Requirements for Improvement – Detail

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.03.05 ESC 60 days

Standard Text: The hospital maintains fire safety equipment and fire safety building features. Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.

Element(s) of Performance:

2. For hospitals that use Joint Commission accreditation for deemed status purposes: At least quarterly, the hospital tests water-flow devices. Every 6 months, the hospital tests valve tamper switches. The completion date of the tests is documented.
Note: For additional guidance on performing tests, see NFPA 25, 1998 edition (Sections 2-3.3 and 3-3.3) and NFPA 72, 1999 edition (Table 7-3.2).
For hospitals that do not use Joint Commission accreditation for deemed status purposes: Every 6 months, the hospital tests valve tamper switches and water-flow devices. The completion date of the tests is documented.
Note: For additional guidance on performing tests, see NFPA 72, 1999 edition (Table 7-3.2).

Scoring Category : A
Score : Insufficient Compliance

12. Every 5 years, the hospital conducts water-flow tests for standpipe systems. The completion date of the tests is documented.
Note: For additional guidance on performing tests, see NFPA 25, 1998 edition.

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:

Observed in Document Review at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
The quarterly fire sprinkler inspection dated February 25, 2016 indicated that 10 water flow devices and 17 tamper switches passed a "visual" inspection - the "operational" box was not checked for any of these devices; therefore, a functional test was not documented. A quarterly fire sprinkler inspection report from a prior sprinkler contractor indicated an inventory of 10 water flow devices and 29 tamper switches, which coincided with the tamper switch inventory in the September 2015 fire alarm test report. A July 2014 fire alarm test report indicated 31 tamper switches were tested. The hospital was not able to account for the difference in tamper switch numbers (17, 29, and 31). An accurate tamper switch inventory was not present.

EP 12
§482.41(c)(2) - (A-0724) - (2) Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality.
This Standard is NOT MET as evidenced by:

Observed in Document Review at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
A 5-year standpipe flow test has not been completed. The documentation presented for this requirement was a 5-year check valve internal inspection completed in 2013.

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.06.01 ESC 60 days

Standard Text: The hospital establishes and maintains a safe, functional environment.
Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

Element(s) of Performance:

1. Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided. 4

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 1
§482.41(a) - (A-0701) - §482.41(a) Standard: Buildings

The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
An unsecured carbon dioxide compressed gas cylinder was observed standing upright in the main kitchen. A securing chain was present, but was laying on the floor. This cylinder did not have a valve guard.

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
The gas cylinder storage room on the 1st floor had approximately 20 oxygen "E" sized compressed gas cylinders grouped together and secured with a wall mounted chain; however, large spaces between cylinders were noted within the chain, allowing for significant cylinder movement within the chain, and thus were not properly secured.

Chapter: Leadership

Program: Hospital Accreditation

Standard: LD.04.01.05 ESC 60 days

Standard Text: The hospital effectively manages its programs, services, sites, or departments.

Element(s) of Performance:

4. Staff are held accountable for their responsibilities. 4

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 4

Observed in Document Review at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site.
In 2 of 2 emergency department records reviewed for an evaluation of moderate sedation care, no pre-sedation evaluation of the patient was found within the record. Staff were not being held accountable for the documentation of the pre-assessment of the patient in this high-risk procedure. Further information from the organization identified that there was no prompt for the documentation of this required assessment in the electronic medical record.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.10 ESC 60 days

Standard Text: Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Element(s) of Performance:

4. Openings in 2-hour fire-rated walls are fire rated for 1 1/2 hours. (See also LS.02.01.20, EP 3; LS.02.01.30, EP 1) (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.3.1) 4

Scoring Category : A
Score : Insufficient Compliance

9. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes that penetrate fire-rated walls and floors are protected with an approved fire-rated material.
Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text and any exceptions, refer to NFPA 101-2000: 8.2.3.2.4.2) 4

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 4
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
In 3 of 10 fire rated door checks, holes were observed in the 90-minute fire rated door or door frame from hardware that had been removed, which voids the 90-minute fire protection rating. The 90-minute fire rated door to Stair 1 on the 3rd floor had a 1/2-inch hole at the top of the door; the 90-minute fire rated door to Stair 2 on the 2nd floor had a two 3/8-inch holes at the top of the door frame; and the 90-minute fire rated door to Stair 1 on the 2nd floor had a 3/8-inch hole at the top of the door frame.

EP 9
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
In 1 of 5 fire rated floor assembly checks, penetrations were not properly sealed. A 4-inch open cable sleeve that penetrated the 2-hour fire rated floor assembly in the 4th floor communication room was not properly sealed with an approved fire stop system.

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
In 2 of 3 fire rated wall checks, penetrations were not sealed. A cable that penetrated the 2-hour fire rated wall through a 2-inch cored hole was observed above the ceiling at Stair 2 on the 2nd floor; and a cable that penetrated the 2-hour fire rated wall through a 2-inch and 1-inch cored holes were observed above the ceiling at Stair 1 on the 2nd floor.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20 ESC 45 days

Standard Text: The hospital maintains the integrity of the means of egress.

Element(s) of Performance:

1. Doors in a means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.2.2.2.4) 3

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
The doors to Stair 1 and Stair 2 on the 2nd floor in the Labor & Delivery Unit were indicated as an exit and were locked in the direction of egress. A card swipe was required to egress. While the hospital had elected to use the CMS categorical waiver that would permit locking of exits for security purposes; the hospital did not meet the categorical waiver requirements as the locked unit did not have a total (complete) smoke detection system throughout the locked space, nor could the locked doors be remotely unlocked from a constantly attended location within the locked space as required by NFPA 101-2012, 19.2.2.2.5.2 (2).

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
The door to Stair 3 on the 2nd floor in the Medical/Surgical Overflow Unit was indicated as an exit and was locked in the direction of egress. A card swipe was required to egress. While the hospital had elected to use the CMS categorical waiver that would permit locking of exits for security purposes; this was neither a patient security nor a clinical need issue. In addition, the hospital did not meet the categorical waiver requirements as the locked unit did not have a total (complete) smoke detection system throughout the locked space, nor could the locked doors be remotely unlocked from a constantly attended location within the locked space as required by NFPA 101-2012, 19.2.2.2.5.2 (2).

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
A cross-corridor door pair in the ER was indicated as an exit and was locked in the direction of egress. This door pair was equipped with a delayed egress magnetic lock; however, there was no "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" sign on the door adjacent to the releasing device as required by NFPA 101-2000, 7.2.1.6.1 (d).

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
The door pair to the ER waiting area from inside the ER by check-in was indicated as an exit and was locked in the direction of egress with a magnetic lock that required a card swipe to egress. While the hospital had elected to use the CMS categorical waiver that would permit locking of exits for security purposes; the hospital did not meet the categorical waiver requirements as the locked unit did not have a total (complete) smoke detection system throughout the locked space, nor could the locked doors be remotely unlocked from a constantly attended location within the locked space as required by NFPA 101-2012, 19.2.2.2.5.2 (2).

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.30 ESC 60 days

Standard Text: The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Element(s) of Performance:

23. Doors in smoke barriers are self-closing or automatic-closing, constructed of 1 3/4-inch or thicker solid bonded wood core or constructed to resist fire for not less than 20 minutes, and fitted to resist the passage of smoke. The gap between meeting edges of door pairs is no wider than 1/8 inch, and undercuts are no larger than 3/4 inch. Doors do not have nonrated protective plates more than 48 inches above the bottom of the door. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.5, 18/19.3.7.6, and 8.3.4.1)

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 23
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
In 3 of 24 smoke barrier door checks, three corridor doors to the main kitchen by the dietary office, the kitchen, and the dish washing area, were located in a smoke barrier wall and did not close completely due to high velocity air movement from the corridor into the kitchen.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.34

ESC 60 days

Standard Text: The hospital provides and maintains fire alarm systems.

Element(s) of Performance:

4. The hospital meets all other Life Safety Code fire alarm requirements related to NFPA 101-2000: 18/19.3.4.

4

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 4
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
Elevator 1 and 2 equipment room (Penthouse) had three (3) ceiling pockets created by 15-inch deep beams, with one smoke detector located on the ceiling in one ceiling pocket. This smoke detector was located immediately in front of a high velocity air supply for the room. A smoke detector was not provided in the other two ceiling pockets as required by NFPA 72-1999, 2-3.4.6.1 since the ceiling beam depth was greater than 12-inches. This smoke detector activates the elevator recall function in the event of a fire in the elevator equipment room; however, a smoke detector in front of a high velocity air supply, or the lack of a smoke detector in the other ceiling pockets, could result in a delay in elevator recall.

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
Elevator 3 and 4 equipment room (Penthouse) had three (3) ceiling pockets created by 15-inch deep beams, with one smoke detector located on the ceiling in one ceiling pocket. This smoke detector was located immediately in front of a high velocity air supply for the room. A smoke detector was not provided in the other two ceiling pockets as required by NFPA 72-1999, 2-3.4.6.1 since the ceiling beam depth was greater than 12-inches. This smoke detector activates the elevator recall function in the event of a fire in the elevator equipment room; however, a smoke detector in front of a high velocity air supply, or the lack of a smoke detector in the other ceiling pockets, could result in a delay in elevator recall.

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
Elevator 5 and 6 equipment room (Penthouse) had three (3) ceiling pockets created by 15-inch deep beams, with one smoke detector located on the ceiling in one ceiling pocket. This smoke detector was located immediately in front of a high velocity air supply for the room. A smoke detector was not provided in the other two ceiling pockets as required by NFPA 72-1999, 2-3.4.6.1 since the ceiling beam depth was greater than 12-inches. This smoke detector activates the elevator recall function in the event of a fire in the elevator equipment room; however, a smoke detector in front of a high velocity air supply, or the lack of a smoke detector in the other ceiling pockets, could result in a delay in elevator recall.

Standard Text: The hospital provides and maintains systems for extinguishing fires.

Element(s) of Performance:

5. Sprinkler heads are not damaged and are free from corrosion, foreign materials, and paint. (For full text and any exceptions, refer to NFPA 25-1998: 2-2.1.1)

Scoring Category : C
Score : Insufficient Compliance

6. There are 18 inches or more of open space maintained below the sprinkler deflector to the top of storage.
Note: Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler head. (For full text and any exceptions, refer to NFPA 13-1999: 5-8.5.2.1)

Scoring Category : C
Score : Insufficient Compliance

14. The hospital meets all other Life Safety Code automatic extinguishing requirements related to NFPA 101-2000: 18/19.3.5.

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 5
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
A fire sprinkler head in patient room 407 above the bed was heavily loaded with foreign materials (dust/dirt/lint). This sprinkler was located next to a supply air diffuser.

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
A fire sprinkler head in ICU patient room 10 above the bed was heavily loaded with foreign materials (dust/dirt/lint). This sprinkler was located next to a supply air diffuser.

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
OR 3 had a concealed sprinkler head with a missing cover plate. The cover plate is part of the listed sprinkler assembly and must be maintained for proper sprinkler function.

EP 6
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
An obstructed fire sprinkler was observed in ICU patient room 10 where a CRT television was mounted to the wall directly below a sprinkler with less than 18-inches clearance below the deflector (5-inches clear).

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
An obstructed fire sprinkler was observed in the 2nd floor Labor and Delivery storage room where storage on a shelf was located directly below a sprinkler with less than 18-inches clearance below the deflector (15-inches clear).

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
An obstructed fire sprinkler was observed in the gift shop storage closet where a supply shelf was located directly below a sprinkler with less than 18-inches clearance below the deflector (14-inches clear).

EP 14
§482.41(b)(1)(i) - (A-0710) - (i) The hospital must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. The Director of the Office of the Federal Register has approved the NFPA 101®2000 edition of the Life Safety Code, issued January 14, 2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the Code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.

Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in this edition of the Code are incorporated by reference, CMS will publish notice in the Federal Register to announce the changes.
This Standard is NOT MET as evidenced by:

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
Ceiling obstructions that would prevent sprinkler discharge from reaching the hazard were observed in Mechanical Penthouse 5 where the fire sprinklers located at the ceiling were obstructed by multiple HVAC ducts greater than 4 feet wide. Sprinklers were not present under these fixed obstructions as required by NFPA 13-1999, 5-6.5.3.1.

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
Ceiling obstructions that would prevent sprinkler discharge from reaching the hazard were observed in Mechanical Penthouse 1 where the fire sprinklers located at the ceiling were obstructed by multiple HVAC ducts greater than 4 feet wide. Sprinklers were not present under these fixed obstructions as required by NFPA 13-1999, 5-6.5.3.1.

Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
The deep fat fryer in the cafeteria serving line was immediately adjacent to an open flame gas charbroiler without the 16-inch separation or 8-inch baffle required by NFPA 96-1998, 9-1.2.3.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.01.01.01 ESC 60 days

Standard Text: Medical staff bylaws address self-governance and accountability to the governing body.

Element(s) of Performance:

5. The medical staff complies with the medical staff bylaws, rules and regulations, and policies. 4

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 5
§482.22(c) - (A-0353) - §482.22(c) Standard: Medical Staff Bylaws

The medical staff must adopt and enforce bylaws to carry out its responsibilities.
The bylaws must:
This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
It was observed that the GI history and physical for a patient was missing vitals (temperature, heart rate, respiratory rate, and blood pressure). This did not comply with the medical staff bylaws regarding a complete history and physical. This was also verified by the organization. During survey, the electronic medical record was updated to auto-populate the GI history and physical form with a patient's vital.

Chapter: Medical Staff

Program: Hospital Accreditation

Standard: MS.05.01.01 ESC 60 days

Standard Text: The organized medical staff has a leadership role in organization performance improvement activities to improve quality of care, treatment, and services and patient safety.

Element(s) of Performance:

2. The medical staff is actively involved in the measurement, assessment, and improvement of the following: Medical assessment and treatment of patients. (See also PI.03.01.01, EPs 1-4)

4

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2

Observed in Record Review at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
In 4 of 4 medical records reviewed for patients who had received moderate sedation performed by a non-anesthesiologist, deficiencies in the quality and completeness of the pre-sedation assessment were identified. For example, in two of two records reviewed for patients who received care in the emergency department, no pre-sedation evaluation of the patient by the proceduralist was found in the record. In two of two interventional radiology cases, no airway assessment was documented in the record. Additionally, one of these records classified a patient with systemic disease, multiple comorbidities and end stage COPD as an ASA II. A previous evaluation by an anesthesiologist during the same admission classified the patient as an ASA IV. The review of the systems documented for this patient in the pre-sedation evaluation had the respiratory review documented as "within normal limits". Further discussion with the two members of the department of anesthesiology revealed that there currently is no mechanism for the medical staff to review the quality of the care and documentation provided for anesthesia administered by non-anesthesiologists.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.02.08 ESC 45 days

Standard Text: The hospital assesses and manages the patient's risks for falls.

Element(s) of Performance:

2. The hospital implements interventions to reduce falls based on the patient's assessed risk.

3

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2

Observed in Tracer Activities at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site.
During a review of the admission assessment for a patient admitted on April 1st, it was noted that the patient had been identified as a high risk for falling. The processes for reducing the risk including a magnet to be placed on the patients door to alert personnel to this risk, as well as other interventions. No magnet was observed on this patient's door during the review of this patient's care on April 12th.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.01.03.01 ESC 45 days

Standard Text: The hospital plans the patient's care.

Element(s) of Performance:

26. Diagnostic computed tomography (CT) imaging protocols are reviewed and kept current with input from an interpreting radiologist, medical physicist, and lead imaging technologist to make certain that they adhere to current standards of practice and account for changes in CT imaging equipment. These reviews are conducted at time frames identified by the hospital.
Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

3

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 26

Observed in Document Review at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site.
During a review of the policy titled, "IV Contrast for Imaging Procedures" last approved 06/2012, it was noted that the policy had a status of "pending". The policy had been revised in the June of 2015 but had not completed the approval process. The new policy was available to staff for implementation without completing the review and approval process. Of note, minor dosing modifications were the only substantive changes between the old and revised versions of the policy.

Chapter: Provision of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: PC.03.05.09 ESC 45 days

Standard Text: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has written policies and procedures that guide the use of restraint or seclusion.

Element(s) of Performance:

2. For hospitals that use Joint Commission accreditation for deemed status purposes: Physicians, clinical psychologists, and other licensed independent practitioners authorized to order restraint or seclusion (through hospital policy in accordance with law and regulation) have a working knowledge of the hospital policy regarding the use of restraint and seclusion.
Note: The definition of 'physician' is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary). 3

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
§482.13(e)(11) - (A-0176) - (11) Physician and other licensed independent practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed independent practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.
This Standard is NOT MET as evidenced by:

Observed in Document Review at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
In 3 of 3 physician files reviewed for evidence of training in restraint and seclusion, there was no evidence that restraint education and evaluation of competence to conduct a face to face assessment had been completed. All three physicians had ordered restraints for violent behavior in medical records that had been reviewed. The organization's "Restraint Usage" policy states that "A face-to-face assessment by a physician or LIP, RN or physician assistant with demonstrated competence must be done within one hour..."

Chapter:	Provision of Care, Treatment, and Services
Program:	Hospital Accreditation
Standard:	PC.03.05.11
Standard Text:	For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital evaluates and reevaluates the patient who is restrained or secluded.

ESC 45 days

Element(s) of Performance:

1. For hospitals that use Joint Commission accreditation for deemed status purposes: A physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse or a physician assistant may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3.
Note 1: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance.
Note 2: The definition of 'physician' is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

3

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 1
§482.13(e)(12)(i)(A) - (A-0178) - (A) Physician or other licensed independent practitioner; or
This Standard is NOT MET as evidenced by:

Observed in Record Review at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
In 2 of 2 medical records reviewed for patients who had been in restraints for violent behavior, there was no documented evidence of a face to face evaluation being conducted by the LIP responsible for the patient's care. The organization's policy titled, "Restraint Usage", policy ID #1992305, last updated 12/2015, was reviewed. It was learned that a modification to the electronic health record is in progress to add a field for documentation of this assessment.

Chapter: Record of Care, Treatment, and Services

Program: Hospital Accreditation

Standard: RC.01.01.01 ESC 60 days

Standard Text: The hospital maintains complete and accurate medical records for each individual patient.

Element(s) of Performance:

19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed. 4

Scoring Category : C
Score : Insufficient Compliance

Observation(s):

EP 19
§482.24(c)(2) - (A-0450) - (2) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner who is responsible for the care of the patient only if such a practitioner is acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.
This Standard is NOT MET as evidenced by:
§482.24(c)(1) - (A-0450) - (1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.
This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
It was observed that the GI history and physical for a patient was signed and dated, but not timed. The form entitled, "GI History and Physical" did not contain a place for the provider to document time. The form was updated to include a place to document time during the time of survey.

Observed in Individual Tracer at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
It was observed that the history and physical for an obstetric patient was signed and dated, but noted timed.

Observed in Individual Tracer at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
In 2 of 2 pre-sedation evaluations reviewed in two separate records, the signature of the physician completing the form was not dated or time.

Observed in Individual Tracer at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
Handwritten pre-procedural orders for an interventional radiology case were reviewed. The orders were taken as a telephone order, then co-signed by the physician. The physician's signature was not dated or timed as to when the authentication of the order had occurred.

Chapter:	Record of Care, Treatment, and Services
Program:	Hospital Accreditation
Standard:	RC.02.01.01 ESC 45 days
Standard Text:	The medical record contains information that reflects the patient's care, treatment, and services.
Element(s) of Performance:	

2. The medical record contains the following clinical information:
- The reason(s) for admission for care, treatment, and services
- The patient's initial diagnosis, diagnostic impression(s), or condition(s)
- Any findings of assessments and reassessments (See also PC.01.02.01, EPs 1 and 4; PC.03.01.03, EPs 1 and 8)
- Any allergies to food
- Any allergies to medications
- Any conclusions or impressions drawn from the patient's medical history and physical examination
- Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric hospitals using Joint Commission accreditation for deemed status purposes: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses.
- Any consultation reports
- Any observations relevant to care, treatment, and services
- The patient's response to care, treatment, and services
- Any emergency care, treatment, and services provided to the patient before his or her arrival
- Any progress notes
- All orders
- Any medications ordered or prescribed
- Any medications administered, including the strength, dose, and route
- Any access site for medication, administration devices used, and rate of administration
- Any adverse drug reactions
- Treatment goals, plan of care, and revisions to the plan of care (See also PC.01.03.01, EPs 1 and 23)
- Results of diagnostic and therapeutic tests and procedures
- Any medications dispensed or prescribed on discharge
- Discharge diagnosis
- Discharge plan and discharge planning evaluation (See also PC.01.02.03, EPs 6-8)

Scoring Category : C
Score : Partial Compliance

Observation(s):

EP 2
§482.24(c)(4)(iii) - (A-0464) - [All records must document the following, as appropriate:]

(iii) Results of all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient.
This Standard is NOT MET as evidenced by:

Observed in Individual Tracer at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard, Smyrna, TN) site for the Hospital deemed service.
In 2 of 2 pre-sedation evaluations conducted for patients who had an interventional radiology procedure under moderate sedation, the section of the form to document the airway assessment was blank. The form has check box options for yes and no in response to the question, "Airway assessment normal? Neither box had been checked for both of the records reviewed.

Opportunities for Improvement – Summary

Observations noted within the Opportunities for Improvement (OFI) section of the report represent single instances of non-compliance noted under a C category Element of Performance. Although these observations do not require official follow up through the Evidence of Standards Compliance (ESC) process, they are included to provide your organization with a robust analysis of all instances of non-compliance noted during survey.

Program:	Hospital Accreditation Program	
Standards:	EC.02.02.01	EP5
	HR.01.02.05	EP5
	HR.01.07.01	EP2
	IC.02.01.01	EP1
	IC.02.02.01	EP4
	LS.02.01.20	EP13
	LS.02.01.30	EP18
	MM.05.01.07	EP2
	RI.01.07.01	EP18

Opportunities for Improvement – Detail

Chapter: Environment of Care

Program: Hospital Accreditation

Standard: EC.02.02.01

Standard Text: The hospital manages risks related to hazardous materials and waste.

Element(s) of Performance:

5. The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP5
Observed in Tracer Activities at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard,Smyrna,TN) site.
No eye was station was available in the dialysis setting where bleach is used to disinfect the machines.

Chapter: Human Resources

Program: Hospital Accreditation

Standard: HR.01.02.05

Standard Text: The hospital verifies staff qualifications.

Element(s) of Performance:

5. Staff comply with applicable health screening as required by law and regulation or hospital policy. Health screening compliance is documented.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP5
Observed in HR File Review at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard,Smyrna,TN) site.
In 1of 7 employee files reviewed for verification of health requirements, respiratory fit testing had not been conducted according to the organization's required timeframe. The employee was due for fit testing in October of 2015 and it had yet to be completed.

The Joint Commission
Findings

Chapter: Human Resources

Program: Hospital Accreditation

Standard: HR.01.07.01

Standard Text: The hospital evaluates staff performance.

Element(s) of Performance:

2. The hospital evaluates staff performance once every three years, or more frequently as required by hospital policy or in accordance with law and regulation. This evaluation is documented.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP2
Observed in HR File Review at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard,Smyrna,TN) site.
The performance evaluation of an employee who works in the Central Sterile Processing setting was reviewed. According to hospital requirements, the evaluation was due to be completed by December 31, 2015, and was completed on April 13, 2016. The evaluation was overdue by several months.

Chapter: Infection Prevention and Control

Program: Hospital Accreditation

Standard: IC.02.01.01

Standard Text: The hospital implements its infection prevention and control plan.

Element(s) of Performance:

1. The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP1
Observed in Tracer Activities at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard,Smyrna,TN) site.
An employee in surgical garb was observed to be entering the physician lounge with a surgical mask hanging from the neck. It was confirmed that the organization follows AORN guidelines. This practice is not consistent with those guidelines.

Chapter: Infection Prevention and Control

The Joint Commission

Findings

Program: Hospital Accreditation

Standard: IC.02.02.01

Standard Text: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

Element(s) of Performance:

4. The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP4
Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard,Smyrna,TN) site. Over 30 packaged cardiac catheters were observed in the 3rd floor mechanical room on top of a supply cart.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.20

Standard Text: The hospital maintains the integrity of the means of egress.

Element(s) of Performance:

13. Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text and any exceptions, refer to NFPA 101 -2000: 7.1.10.1)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP13
Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard,Smyrna,TN) site. One of the OR perimeter exit access corridors was obstructed by surgical equipment and supplies stored along the entire length of the corridor. The OR was not identified as a suite on the Life Safety Code drawings.

Chapter: Life Safety

Program: Hospital Accreditation

Standard: LS.02.01.30

Standard Text: The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Element(s) of Performance:

18. Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text and any exceptions, refer to NFPA 101-2000: 18/19.3.7.3)

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP18
Observed in Building Tour at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard,Smyrna,TN) site. In 1of 8 smoke barrier wall checks, penetrations were not sealed. A 1/2-inch open flexible conduit that penetrated the smoke barrier wall above the ceiling inside patient room 215 was not sealed.

Chapter: Medication Management

Program: Hospital Accreditation

Standard: MM.05.01.07

Standard Text: The hospital safely prepares medications.

Element(s) of Performance:

2. Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for product preparation to avoid contamination of medications.

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP2
Observed in Tracer Activities at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard,Smyrna,TN) site.
The tray used to bring prepared single patient IV medications to the nuclear medicine cardiac stress testing area for injection was observed to have an absorbent paper taped to it. The paper was visibly worn and discolored.

Chapter: Rights and Responsibilities of the Individual

The Joint Commission
Findings

Program:	Hospital Accreditation
Standard:	RI.01.07.01
Standard Text:	The patient and his or her family have the right to have complaints reviewed by the hospital.

Element(s) of Performance:

18. For hospitals that use Joint Commission accreditation for deemed status purposes: In its resolution of complaints, the hospital provides the individual with a written notice of its decision, which contains the following:
- The name of the hospital contact person
- The steps taken on behalf of the individual to investigate the complaint
- The results of the process
- The date of completion of the complaint process

Scoring Category : C
Score : Satisfactory Compliance

Observation(s):

EP18
Observed in Document Review at TriStar StoneCrest Medical Center (200 StoneCrest Boulevard,Smyrna,TN) site.
In 1of 2 reviews of grievance follow up, no final written notice of the decision to the patient was able to be provided by the organization. The grievance was received on 7/16 with an initial letter sent to acknowledge receipt of the complaint and that further notification of the outcome was pending. No second letter with the resolution was available for the surveyor to review.

Plan for Improvement - Summary

The Plan for Improvement (PFI) items were extracted from your Statement of Conditions™ (SOC) and represent all open and accepted PFIs during this survey. The number of open and accepted PFIs does not impact your accreditation status, and is fully in sync with the self-assessment process of the SOC. The implementation of Interim Life Safety Measures (ILSM) must have been assessed for each PFI. The Projected Completion Date within each PFI replaces the need for an individual ESC (Evidence of Standards Compliance) so the corrective action must be achieved within six months of the Projected Completion Date. Future surveys will review the completed history of these PFIs.

Number of PFIs: 0

TriStar StoneCrest Medical Center

2016 TJC Survey Action Plan

ESC for Direct findings due 5/30/16

ESC for Indirect findings due 6/14/16

	TJC Findings
Indirect	LD.04.01.05 EP 5 *Staff are held accountable for their responsibilities* No documentation of pre-sedation assessment
Indirect	MS.01.01.01 EP 5 *The medical staff complies with the bylaws, rules and regs and policies* GI H&P was missing vital signs
Indirect	MS.05.01.01 EP 2 *Medical staff is actively involved in measurement and improvement of medical assessment and Tx of patients* Quality and completeness of pre-sedation assessments-no airway assessments, improper ASA classification. No anesthesia oversight of moderate sedation quality

TriStar StoneCrest Medical Center

2016 TJC Survey Action Plan

ESC for Direct findings due 5/30/16

ESC for Indirect findings due 6/14/16

	TJC Findings
Direct	PC.01.02.08 EP 2 *Hospital implements interventions to reduce falls* Missing magnet on the door of a patient at high risk for falls
Direct	PC.01.03.01 EP 26 *CT protocols are reviewed and kept current* CT protocols not fully approved
Direct	PC.03.05.09 EP 2 *LIPs authorized to order restraints must have a working knowledge of hospital policy* No documentation of physician education of the restraint policy or demonstrated competency to do the 1 hour face to face evaluation

TriStar StoneCrest Medical Center

2016 TJC Survey Action Plan

ESC for Direct findings due 5/30/16

ESC for Indirect findings due 6/14/16

Direct	PC.03.05.11 EP 1 *LIP, RN or PA performs an in person evaluation within one hour of application of violent restraints* No documentation of 1 hour face to face evaluation
Indirect	RC.01.01.01 EP 19 *All entries in the medical record are timed* Times missing form OB H&P, pre-sedation evaluations, authentication of telephone order
Direct **MOS DUE**	RC.02.01.01 EP 2 *The medical record contains all relevant clinical information* Missing airway assessments on pre-sedation evaluations

Miscellaneous Information

Anesthesia Commitment Letter
TennCare Enrollment
Quality Assurance Documents
Support Letters

NASHVILLE ANESTHESIA SERVICES

JAMES T. BYLAND, MD
BRADLEY C. FRY, MD
HUGH L. HEAD, MD
STEPHEN J. OBERMEIER, MD
DAVID H. VICKERS, MD
VOLKER I. STRIEPE, MD
JOHN M. LEVOY, MD

MAILING ADDRESS
P.O. BOX 468
MADISON, TN 37116

July 20, 2017

Lou Caputo, Chief Executive Office
TriStar StoneCrest Medical Center
200 StoneCrest Blvd.
Smyrna, TN 37167

Dear Mr. Caputo,

This letter is to confirm that our group, Nashville Anesthesia Services would be pleased to provide anesthesia services for the proposed StoneCrest Surgery Center, subject to final contract negotiations after you receive CON approval.

We are a group of nine Board-certified anesthesiologists currently providing coverage at TriStar StoneCrest Medical Center and TriStar Southern Hills Medical Center. We are currently contracted with all area TennCare and MCOs in StoneCrest's service areas.

Please let me know if any additional information would be helpful at this time.

Respectfully,

Bradley C. Fry, MD
Anesthesiologist
Nashville Anesthesia Services

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

JOHN WELLBORN, being first duly sworn, says that he is the lawful agent of the applicant named in this application, that this project will be completed in accordance with the application to the best of the agent's knowledge, that the agent has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete to the best of the agent's knowledge.

SIGNATURE/TITLE
CONSULTANT

Sworn to and subscribed before me this 24th day of July (Month), 2017 (Year) a Notary

Public in and for the County/State of DAVIDSON

JAN M. DANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 2, 2018

NOTARY PUBLIC

My commission expires July 2 (Month/Day), 2018 (Year).

Supplemental #1
(COPY)

StoneCrest Surgery Center

CN1707-023

221

JUL 31 2017 8:25

SUPPLEMENTAL #1
July 31, 2017
8:27 am

July 31, 2017

Phillip M. Earhart, HSD Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application #1707-023
StoneCrest Surgery Center

Dear Mr. Earhart:

Our July 28 response to your July 27 first supplemental request on the subject application was filed in pdf format by our attorney's office so that it would be available to you late Friday afternoon--there not being time to transport the original version from my office to the HSDA office.

This letter transmits the original (and two photocopies) of the first supplemental response from which the pdf was scanned. These provide the staff and Board with much clearer resolution of the text and of certain tables.

We request that these be substituted for the July 28 pdf filing. If required, you may take this as a request for withdrawal of the July 28 submittal, and a July 31 submittal of the attached.

Thank you for your assistance.

Respectfully,

John Wellborn

John Wellborn
Consultant

4219 Hillsboro Road, Suite 203
Nashville, TN 37215

jwdsg@comcast.net

Tel 615.665.2022
Fax 615.665.2042

DSG Development Support Group

SUPPLEMENTAL #1
July 31, 2017
8:27 am

July 28, 2017

Phillip M. Earhart, HSD Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application #1707-023
StoneCrest Surgery Center

Dear Mr. Earhart:

This letter responds to your recent request for additional information on this application received on July 27. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. **Please provide the members and ownership entity and each member's percentage of ownership, for those with 5% ownership (direct and indirect) interest for the following: Frisco, Inc. and Hercules Holding II, Inc.**

   HCA Healthcare, Inc. is publicly traded on the New York Stock Exchange and does not know the identities of all of the owners of its approximately 360,000,000 outstanding shares of stock. Hercules Holding II and Frisco, Inc. are privately-held companies that respectively own approximately 18% and 9.5% (indirectly) of the common stock of HCA Healthcare, Inc., and therefore have indirect ownership interests of at least 5% in the applicant. To our knowledge, none of the members of Hercules Holding II or stockholders of Frisco, Inc. holds a 5% or greater direct or indirect ownership interest in the applicant.

2. **Section A, Project Details, Item 5.A Name of Management/Operating Entity**

   Please provide a website address for Medical Care America, LLC and submit a replacement page 12.

   Medical Care America does not have a website. It is affiliated with HCA Healthcare, Inc., whose website address is https://hcahealthcare.com/about/hca-at-a-glance.dot, as noted on the replacement page 12R attached on the following page.

4219 Hillsboro Road, Suite 203
Nashville, TN 37215

jwdsg@comcast.net

Tel 615.665.2022
Fax 615.665.2042

3. Section A, Project Details, Item 6.B (1)

The plot plan is noted. However, please provide a plot plan that includes the names of streets, roads, highways that cross or border the site and submit.

The revised plot plan is attached following this page.

4. Section A, Project Details, Item 12 Square Footage and Cost Per Square Footage Chart

Please provide a brief description of the 13,000 SF building that will be constructed. Will the building be designed for possible future expansion vertically or horizontally?

The building will be constructed of steel. Its exterior will consist of glass, brick, and EFIS on metal studs to be consistent with the hospital and MOB properties nearby. It is a one story building with no plans to expand vertically. A horizontal expansion of surgical room capacity is possible with the initial design submitted in this application.

5. Section B, Need, Page 23

a. The table on page 23 is noted. However, there appears to be a typo in four Rutherford County ZIP codes (32127, 32128, 32129, and 32130) in the table and other tables within the application. Please correct and submit replacement s pages.

All the pages with that typographical error have been corrected and are attached at the end of this letter with their designation as replacement pages, i.e. page 23R.

b. Please clarify how many cases represent operating room and procedure room capacity in the table on page 23.

Please see the revised table on the following page, revised page 23R. In summary, it shows the following:

Utilization of ASTC Surgical Rooms in Project Service Area--2016		
	2016 Percent of Full (100%) Utilization	**2016 Percent of Optimal (100%) Utilization**
Operating Rooms		
All 6 ASTC's	72.78%	103.98%
3 Multispecialty ASTCs	76.95%	109.94%
5 ASTC's Excluding Podiatry ASTC	77.24%	110.35%
Procedure Rooms		
All 6 ASTC's	62.86%	89.80%
3 Multispecialty ASTCs	57.47%	82.10%
5 ASTC's Excluding Podiatry ASTC	62.86%	89.80%

6. Section B, Need, (Specific Criteria –ASTC) Item 1. Operating Rooms

a. It is noted the applicant projects an average of 92 minutes per case in Year Two. Please indicate the reason this is higher than the estimated average time per case standard of 65 minutes.

Thank you for bringing that error to the applicant's attention. The Surgery Center Division has corrected the total case time to 65 minutes based on a 50-minute case time more in line with their experience. Please see the table submitted in response to question 7a below.

b. Please explain the reasons OP cases at StoneCrest Medical Center decreased from 3,648 in 2013 to 2,971 in 2016.

One reason was a loss of surgeons. The busiest urologist on staff relocated to California for family reasons. Two busy general surgeons also moved out of State, along with an ENT with a large case volume. While new surgeons have been recruited it takes time for their practices to become established and to experience significant growth. In addition the hospital has seen cases shifting to surgery centers, for the reasons stated in the application's Need narratives.

c. The table on page 31 is noted. Please indicate the reasons cases in procedure rooms increased from 1,367 in 2013 to 3,138 annualized in 2017.

The hospital added a gastroenterologist to the staff in late 2014, expanded its GI service capabilities, and improved its technology.

d. The StoneCrest Surgery Center surgical room utilization Year Two (CY2021) table on page 30a is noted. Please complete the same type of chart for StoneCrest Medical Center for CY2021.

This will be submitted under separate cover.

e. Will the shift of patients from the hospital to the ASTC result in significant underutilized surgical space on the Stonecrest campus overall?

The campus-wide surgical room utilization table on page 54 of the application shows projected annual increases of 3.8% in total surgical cases on the campus, from now through Year Two of the project. So the project itself is not causing any decreased overall campus utilization. It is increasing total O.R. and procedure room capacity from 11 to 14 rooms, so temporarily there will be slightly lower average surgical room occupancies on the campus overall. And the outpatient case transfer from the hospital to the new facility will also temporarily create more available time in the hospital surgical suite.

However, time will erase this available capacity as population grows and as StoneCrest Medical Center increases the acuity of its surgical cases in the years ahead. The temporary increase in available O.R. time will not significantly reduce the Surgical Department's financial strength, as shown in that Department's Projected Data Chart.

7. Section B, Need, (Specific Criteria –ASTC) Item 1. Procedure Rooms

a. It appears the average total time per procedure case is projected to be 37 minutes in Year Two. Please indicate the reasons the estimated average per case will be above the 30 minute standard.

That was a typographical error in the average total time per procedure case in the submitted application. This has been corrected on the table following this page.

b. Please confirm the average clean up and preparation between procedure room cases is projected at 7 minutes in Year Two.

This room is projected to be used for GI endoscopies and 7 minutes for a non-sterile procedure room is an average turnaround time for many GI endoscopy cases in this company.

8. Section B, Need, (Specific Criteria –ASTC) Item 2. Need and Economic Efficiencies

Please project cases in Year One and Year Two by Specialty.

Supplemental Table: Estimated Cases By Specialty		
	Year One	Year Two
ENT	199	205
General Surgery	353	364
Gastroenterology	500	515
Gynecology	233	240
Orthopedic	304	313
Podiatry	112	115
Urology	237	244
Plastic Surgery	12	12
Totals	1,950	2,008

Supplemental Table: Surgical Room Utilization Year Two (CY 2021)
StoneCrest Surgery Center

Surgical Rooms	Cases	Cases/Room	Average Room Minutes Used/Case	Average Turnaround Minutes/Case	Average Total Minutes Per Case	Total Minutes Required for Projected Cases	Schedulable Minutes of Room Capacity*	Utilization % of Schedulable Minutes (120,000 Minutes)	Utilization % of Optimal Utilization OR = 884 PR = 1,867
Operating Room #1	747	747	50.0	15.0	65.0	48,555	120,000	40.5%	84.4%
Operating Room #2	746	746	50.0	15.0	65.0	48,490	120,000	40.4%	84.4%
O.R's Subtotal	1,493	746.5	50.0	15.0	65.0	97,045	240,000	40.4%	84.4%
Procedure Room	515	515	20	7	27	13,905	120,000	11.6%	27.6%
Total Surgical Suite	*2,008*	*669*	*42*	*13*	*55*	*110,950*	*360,000*	30.8%	*55.2%*

** 8 hours X 250 days X 60 minutes per hour = 120,000 Schedulable Minutes = SHP standard for 100% Utilization of a surgical room.*

Note: Case minute data are approximate due to roundings in calculations, and will not total exactly to total required case minutes that are taken from specialty-specific table.

Supplement 1

Supplemental Table--ASTC Utilization by Room Type In Counties That Contain the Primary Service Area StoneCrest Surgery Center				
Multi-Specialty ASTC's	**2014**	**2015**	**2016**	**% Change 2014-16**
Operating Rooms	57	58	57	0.0%
Cases	51,773	52,743	55,072	6.4%
Cases per O.R.	908	909	966	6.4%
Procedure Rooms	15	17	16	6.7%
Cases	14,506	15,413	17,105	17.9%
Cases per PR	967	907	1,069	10.5%
Single-Specialty ASTC's	**2014**	**2015**	**2016**	**% Change 2014-16**
Operating Rooms	11	13	13	18.2%
Cases	8,147	9,286	9,794	20.2%
Cases per O.R.	741	714	753	1.7%
Procedure Rooms	33	33	33	0.0%
Cases	37,500	36,583	34,494	-8.0%
Cases per PR	1,136	1,109	1,045	-8.0%

Source: JARs 2014-2016

9. Section B, Need, (Specific Criteria –ASTC) Item 3.

a. Please complete the following table for the proposed 3 county service area ASTCs.

Multi-Specialty	**2014**	**2015**	**2016**	**% Change from 14-16**
Operating Rooms				
Cases				
Case Per OR				
Procedure Rooms				
Cases				
Cases Per PR				
Single-Specialty	**2014**	**2015**	**2016**	**% Change from 14-16**
Operating Rooms				
Cases				
Case Per OR				
Procedure Rooms				
Cases				
Cases Per PR				

Please see the attached table following this page.

b. Please provide the 3 county proposed service area hospital outpatient surgical utilization from the latest three year period in the following table:

County	Hospital	2013 Cases	2014 Cases	2015 Cases	% Change 2013-2015
	Total				

Please see the attached table on the second following page.

Supplemental Table--Hospital Outpatient Surgery Cases in Counties That Contain the Primary Service Area--2014-2016 StoneCrest Surgery Center					
County	**Hospital**	**2013 Outpatient Surgery Cases**	**2014 Outpatient Surgery Cases**	**2015 Outpatient Surgery Cases**	**% Change 2013-2015**
Rutherford	Saint Thomas Rutherford Hospital	4,376	4,422	4,992	14.1%
	StoneCrest Medical Center	5,015	4,920	5,455	8.8%
Williamson	Williamson Medical Center	6,534	6,516	6,039	-7.6%
Davidson	Metro Nashville General Hospital	2,947	2,969	2,707	-8.1%
	Saint Thomas Hospital for Specialty Surgery	2,199	2,387	2,270	3.2%
	Saint Thomas Midtown Hospital	6,274	5,832	5,556	-11.4%
	Saint Thomas West Hospital	3,253	3,375	3,699	13.7%
	TriStar Centennial Medical Center	1,630	8,935	13,155	707.1%
	TriStar Skyline Medical Center	2,632	2,120	2,319	-11.9%
	TriStar Southern Hills Medical Center	2,391	2,456	2,412	0.9%
	TriStarSummit Medical Center	3,005	2,868	3,119	3.8%
	Vanderbilt University Hospital	29,901	30,752	35,575	19.0%
3-County Total		**70,157**	**77,552**	**87,298**	**24.4%**

Source: Joint Annual Reports, 2013-2015

c. Please provide 2016 patient origin by ZIP Code for outpatient surgery at StoneCrest Medical Center.

The proposed surgery center will derive its patients from outpatient surgery patients that have been coming to StoneCrest Medical Center.

The hospital identified the zip codes from which unduplicated patients' outpatient surgery cases came, during CY2016 and the first half of CY2017. Please see the two-page table beginning on the following page. It shows the zip codes that accounted for approximately 94% of the hospital's surgical outpatients from January 2016 through June 2017.

From this group, this application's primary service area zip codes were identified as contiguous zip codes that contributed 1% of more of surgical outpatients during both 2016 and 2017. Those ten zip codes together contributed 83% of the surgical outpatients during the 18-month study period.

StoneCrest Medical Center
OP Surgery Cases by Zip Code
FY 2016 - June 2017

Year-Month	(All)
Patient_Zip_and_City	(All)
Phys_Surg_Specialty	(All)

Supplemental 1

		AdmitYear Values						
		2016		2017		Total Cases	Total % Cases	10-Zip
Patient_Zip_cde	Patient_County_and_State	Cases	% Cases	Cases	% Cases			PSA
37167	RUTHERFORD - TN	1,707	33.43%	867	32.56%	2,574	33.13%	33.13%
37086	RUTHERFORD - TN	825	16.16%	415	15.58%	1,240	15.96%	49.09%
37129	RUTHERFORD - TN	470	9.20%	244	9.16%	714	9.19%	58.28%
37013	DAVIDSON - TN	371	7.27%	203	7.62%	574	7.39%	65.67%
37128	RUTHERFORD - TN	352	6.89%	177	6.65%	529	6.81%	72.48%
37130	RUTHERFORD - TN	211	4.13%	135	5.07%	346	4.45%	76.93%
37127	RUTHERFORD - TN	80	1.57%	59	2.22%	139	1.79%	78.72%
37135	WILLIAMSON - TN	65	1.27%	51	1.92%	116	1.49%	80.22%
37211	DAVIDSON - TN	76	1.49%	45	1.69%	121	1.56%	81.77%
37217	DAVIDSON - TN	58	1.14%	35	1.31%	93	1.20%	82.97%
37122	WILSON - TN	50	0.98%	30	1.13%	80	1.03%	84.00%
37027	WILLIAMSON - TN	23	0.45%	29	1.09%	52	0.67%	84.67%
37160	BEDFORD - TN	62	1.21%	25	0.94%	87	1.12%	85.79%
37085	RUTHERFORD - TN	25	0.49%	18	0.68%	43	0.55%	86.34%
37153	RUTHERFORD - TN	36	0.71%	15	0.56%	51	0.66%	87.00%
37037	RUTHERFORD - TN	66	1.29%	15	0.56%	81	1.04%	88.04%
37355	COFFEE - TN	33	0.65%	15	0.56%	48	0.62%	88.66%
37110	WARREN - TN	21	0.41%	14	0.53%	35	0.45%	89.11%
37190	CANNON - TN	27	0.53%	14	0.53%	41	0.53%	89.64%
37090	WILSON - TN	20	0.39%	11	0.41%	31	0.40%	90.04%
37214	DAVIDSON - TN	16	0.31%	9	0.34%	25	0.32%	90.36%
37207	DAVIDSON - TN	10	0.20%	8	0.30%	18	0.23%	90.59%
37020	BEDFORD - TN	19	0.37%	8	0.30%	27	0.35%	90.94%
37330	FRANKLIN - TN	7	0.14%	7	0.26%	14	0.18%	91.12%
37064	WILLIAMSON - TN	9	0.18%	7	0.26%	16	0.21%	91.32%
37087	WILSON - TN	16	0.31%	7	0.26%	23	0.30%	91.62%
37138	DAVIDSON - TN	4	0.08%	7	0.26%	11	0.14%	91.76%
37060	RUTHERFORD - TN	11	0.22%	6	0.23%	17	0.22%	91.98%
37388	COFFEE - TN	16	0.31%	5	0.19%	21	0.27%	92.25%
37076	DAVIDSON - TN	13	0.25%	5	0.19%	18	0.23%	92.48%
37091	MARSHALL - TN	11	0.22%	5	0.19%	16	0.21%	92.69%
37342	COFFEE - TN	6	0.12%	5	0.19%	11	0.14%	92.83%

Source: EDW

Zip Code

StoneCrest Medical Center
OP Surgery Cases by Zip Code
FY 2016 - June 2017

Year-Month	(All)
Patient_Zip_and_City	(All)
Phys_Surg_Specialty	(All)

Supplemental 1

233

		AdmitYear	Values					
		2016		2017		Total Cases	Total % Cases	10-Zip
37221	DAVIDSON - TN	4	0.08%	5	0.19%	9	0.12%	92.95%
37014	WILLIAMSON - TN	13	0.25%	5	0.19%	18	0.23%	93.18%
37334	LINCOLN - TN	8	0.16%	5	0.19%	13	0.17%	93.35%
37018	COFFEE - TN	7	0.14%	5	0.19%	12	0.15%	93.50%
37174	MAURY - TN	12	0.24%	5	0.19%	17	0.22%	93.72%
37149	CANNON - TN	15	0.29%	5	0.19%	20	0.26%	93.98%

SUPPLEMENTAL #1
July 31, 2017
8:27 am

SUPPLEMENTAL #1
July 31, 2017
8:27 am

10. Section B, Need, (Specific Criteria –ASTC) Item 4 and Section B. Contribution to Orderly Development Item 2 Impact to Existing Providers

Please complete the following table for the 3 county service area (Davidson, Rutherford, and Williamson) using 2016 Joint Annual Report Data.

County	ASTC	# ORs	# OR Cases	# Cases per OR	% of meeting 884 Minimum		# PRs	# PR Cases	# Cases per PR	% of Meeting 1,867 Minimum
Service Area	Single-Specialty Subtotal									
	Multi-specialty ASTCs									
Service Area	Multi-specialty ASTCs Subtotal									
	Grand Total/Average									

Please see the supplemental table following this page.

Supplemental Table: Ambulatory Surgical Center Cases in Counties That Contain the Primary Service Area--2014 to 2016
StoneCrest Surgery Center

			2014						2015						2016								
County	ASTC		O.R.s	O.R. Cases	Cases Per O.R.	Proced. Rooms	P.R. Cases	Cases Per P.R.	O.R.s	O.R. Cases	Cases Per O.R.	Proced. Rooms	P.R. Cases	Cases Per P.R.	O.R.s	O.R. Cases	Cases Per O.R.	% O.R. Change 2014-2016	JAR % Utiliz. Of 884 Cases	Proced. Rooms	P.R. Cases	Cases Per P.R.	% P.R. Change 2014-2016	JAR % Utiliz. Of 1,867 Cases
Davidson	Baptist Ambulatory Surgery Center	M	6	5,687	948	1	1,381	1,381	6	5,723	954	1	1,829	1,829	6	5,321	887		100.3%	1	1,260	1,260		67.5%
Davidson	Baptist Plaza Surgicare (dba St. Thomas SC)	M	9	7,635	848	1	459	459	10	7,318	732	2	919	460	9	8,487	943		106.7%	1	282	282		15.1%
Davidson	Centennial Surgery Center	M	6	4,973	829	2	1,801	901	6	6,058	1,010	2	980	490	6	5,216	869		98.3%	2	2,315	1,158		62.0%
Davidson	Northridge Surgery Center	M	5	2,290	458	2	360	180	5	1,766	353	2	538	269	5	2,171	434		49.1%	2	313	157		8.4%
Davidson	Southern Hills Surgery Center	M																						
Davidson	St. Thomas Campus Surgicare	M	6	5,108	851	1	970	970	6	5,963	994	1	1,240	1,240	6	5,973	996		112.6%	1	1,317	1,317		70.5%
Davidson	St. Thomas Outpatient Neurological Center	M	2	3,890	1,945	1	0	0	2	4,500	2,250	1	0	0	2	4,589	2,295		259.6%	1	0	0		0.0%
Davidson	Summit Surgery Center	M	5	4,826	965	1	513	513	5	4,105	821	1	264	264	5	4,983	997		112.7%	1	428	428		22.9%
Davidson	Turner Surgery Center	M																						
Rutherford	Middle Tennessee Ambulatory Surgery Center	M	6	5,609	935	1	666	666	6	5,837	973	1	873	873	6	6,214	1,036		82.0%	1	934	934		50.0%
Rutherford	Physicians Pavilion Surgery Center	M	4	2,272	568	1	551	551	4	1,991	498	1	568	568	4	2,183	546		43.2%	1	694	694		37.2%
Rutherford	Surgicenter of Murfreeesboro Medical Clinic	M	3	3,729	1,243	3	5,138	1,713	3	4,034	1,345	3	5,456	1,819	3	4,237	1,412		111.8%	3	6,036	2,012		107.8%
Williamson	Cool Springs Surgery Center	M	5	5,754	1,151	1	2,667	2,667	5	5,448	1,090	2	2,746	1,373	5	5,698	1,140		128.9%	2	3,526	1,763		94.4%
	MULTI-SPECIALTY FACILITY TOTALS		***57***	***51,773***	***908***	***15***	***14,506***	***967***	***58***	***52,743***	***909***	***17***	***15,413***	***907***	***57***	***55,072***	***966***	***6.4%***	***109.3%***	***16***	***17,105***	***1,069***	***17.9%***	***57.3%***
Davidson	American Endoscopy Center (GI)	S	1	541	541	0	0	0	1	557	557	0	0		1	505	505		57.1%	0	0	0		0.0%
Davidson	Associated Endoscopy (GI)	S	0	0	0	3	5,031	1,677	0	0	0	3	5,453	1,818	0	0	0		0.0%	3	5,593	1,864		99.9%
Davidson	Delozier Surgery Center	S	1	426	426	0	0	0	1	457	457	0	0		1	449	449		50.8%	0	0	0		0.0%
Davidson	Digestive Disease Endoscopy Center (GI)	S	0	0	0	4	6,695	1,674	0	0	0	4	6,620	1,655	0	0	0		0.0%	4	6,059	1,515		81.1%
Davidson	Gurley Surgery Center	S	0	0	0	3	239	80	0	0	0	3	246	82	0	0	0		0.0%	3	180	60		3.2%
Davidson	Mid-State Endoscopy Center (GI)	S	0	0	0	3	2,436	812	0	0	0	3	2,621	874	0	0	0		0.0%	3	2,755	918		49.2%
Davidson	Nashville Endo Surgery Center (GI)	S	0	0	0	3	2,870	957	0	0	0	3	3,106	1,035	0	0	0		0.0%	3	3,633	1,211		64.9%
Davidson	Nashville Gastrointestinal Endoscopy (GI)	S	0	0	0	3	2,594	865	0	0	0	3	2,750	917	0	0	0		0.0%	3	2,853	951		50.9%
Davidson	Oral Facial Surgery Center	S	3	1,453	484	0	0	0	3	2,587	862	0	0		3	2,664	888		100.5%	0	0	0		0.0%
Davidson	Premier Orthopedic Surgery Center (Ortho)	S	2	2,543	1,272	0	0	0	2	2,165	1,083	0	0		2	2,029	1,015		80.3%	0	0	0		0.0%
Davidson	Southern Endoscopy Center (GI)	S	0	0	0	3	2,711	904	0	0	0	3	3,356	1,119	0	0	0		0.0%	3	315	105		5.6%
Davidson	St. Thomas Med. Group Endoscopy Center (GI)	S	0	0	0	2	4,435	2,218	0	0	0	2	3,505	1,753	0	0	0		0.0%	2	3,363	1,682		90.1%
Davidson	Urology Surgery Center	S	3	3,117	1,039	3	3,867	1,289	3	2,436	812	3	3,654	1,218	3	2,820	940		106.3%	3	3,151	1,050		56.3%
Rutherford	Mid-State Endoscopy Center (GI)	S	0	0	0	2	3,209	1,605	0	0	0	2	2,160	1,080	0	0	0		0.0%	2	2,395	1,198		64.1%
Rutherford	Williams Surgery Center (Podiatry)	S	1	67	67	0	0	0	1	56	56	0	0		1	44	44		3.5%	0	0	0		0.0%
Williamson	Crossroads Surgery Center (Pain)	S	0	0	0	2	669	335	0	0	0	2	137	69	0	0	0		0.0%	2	748	374		20.0%
Williamson	Franklin Endoscopy Center (GI)	S	0	0	0	2	2,744	1,372	2	1,028	514	2	2,975	1,488	2	1,283	642		72.6%	2	3,449	1,725		92.4%
	SINGLE-SPECIALTY FACILITY TOTALS		***11***	***8,147***	***741***	***33***	***37,500***	***1,136***	***13***	***9,286***	***714***	***33***	***36,583***	***1,109***	***13***	***9,794***	***753***	***20.2%***	***85.2%***	***33***	***34,494***	***1,045***	***-8.0%***	***56.0%***
	THREE-COUNTY TOTALS		***68***	***59,920***	***881***	***48***	***52,006***	***1,083***	***71***	***62,029***	***874***	***50***	***51,996***	***1,040***	***70***	***64,866***	***927***	***8.3%***	***104.8%***	***49***	***51,599***	***1,053***	***-0.8%***	***56.4%***

Source: Joint Annual Reports 2014-2016.
Note: Excludes single-specialty facilities performing surgery types not projected for StoneCrest Surgery Center (e.g. pain, ophthalmology, etc.)

SUPPLEMENTAL #1
July 31, 2017
8:27 am

b. Please explain in detail where the projected volume of patients for the ASTC are currently receiving outpatient surgical services and what impact this project will have on the utilization of the medical center's surgical suites.

They are currently receiving outpatient surgical services at StoneCrest Medical Center. They are patients identified as having used StoneCrest for that purpose during 2016 and the first half of 2017. 83% of them came from ten contiguous zip codes. That number of cases was projected forward at approximately 3.8% per year to derive total campus cases; and a portion of the total cases were allocated to the surgery center as its projected case volumes.

The impact on the medical center's surgical suite will be a temporary decline in Year One of the project, followed by a gradual restoration of hospital surgical suite utilization over the projection period. This is set forth in narratives and data tables in several sections of the application, in detail.

11. Section B, Need, (Specific Criteria –ASTC) Item 6. Access to ASTCS

The table of mileage and drive times between project and major communities is noted. However, is the distance to Antioch of 40 miles accurate? Please clarify.

That typographical error has been corrected on revised page 37R, attached following this page.

12. Section B, Need Item 1(Specific Criteria –ASTC) Item 10, Patient Safety and Quality of Care: Health Care Workforce (b).

Please complete the table on page 40 of the availability of physicians by specialty that are expected to utilize the facility and of appropriate and qualified staff that will provide ancillary support services, whether on-or off-site.

Attached following this page is revised page 40R completed for Year One of the project. It provides the anticipated medical staff complement by specialty. The Staffing Table in the application documents the appropriate staff for the facility, specifying types and FTE's of staff required.

13. Section B, Need, (Specific Criteria –ASTC) Item 11 Access to ASTCs

The applicant refers to Attachment C-Need-1.A. to document federally underserved areas in the proposed service area. However, the attachment could not be located in the application. The index in the application refers to the attachment as "B-Need State Health Plan-A." Please clarify.

The reference to C-Need-1.A was an error. Attached after this page is revised page 41R correcting the reference to Attachment B-Need-State Health Plan 11a. and correcting the number of that criterion to "11". Also attached is revised page 87R, the corrected Index to the Attachments.

Parts of the service area that are designated as Medically Underserved Areas are identified in materials attached at the end of this response letter.

14. Section B, Need Item 1(Specific Criteria –ASTC) Item 11.a.. Medically Underserved Areas and 11.c.

a. The applicant refers to Attachment C-Need-1.A. to document federally underserved areas of the proposed service area. However, the attachment could not be located in the application. The index in the application refers to the attachment as "B-Need State Health Plan-A." Please clarify.

This is clarified and corrected in response to question 13 immediately above.

b. It appears the applicant incorrectly numbered number "11. Access to ASTCs" as number #1. Please clarify and submit a replacement page 41 if necessary.

This is clarified and corrected in response to question 13 above.

c. Please clarify if the location of the proposed ASTC is physically located in a medically underserved area of Rutherford County.

It is not.

15. Section B, Need Item 3 Service Area

The table on page 43 is noted. However, four Rutherford County ZIP codes appear to have typos. Please clarify.

These have been corrected in the revised pages at the back of this letter.

16. Section B, Need Item 4A (1) Population Demographics

a. If possible, please provide the 2017 and 2021 projected population of the cities of Smyrna and Murfreesboro.

The area Chamber of Commerce has provided the applicant with the following 2017 and 2022 population estimates:

	2017 Population Estimate	2022 Population Projection
Smyrna	47,926	52,361
Murfreesboro	132,379	143,942

b. Please clarify if the location of the proposed ASTC is physically located in a medically underserved area of Rutherford County.

It is not.

17. Section B. Economic Feasibility Item 2 Funding

Please provide the referenced funding letter.

The letter is provided following this page.

18. Section B. Economic Feasibility Item 6. C. Capitalization Ratio

Please provide the requested capitalization ratio.

To be submitted under separate cover.

19. Section B. Economic Feasibility Item 7 Projected Payor Mix

It is noted commercial insurance will represent 50.9% of the total revenue of the proposed project. In the past HCA affiliated facilities were not enrolled in the Blue Cross S plan. Please indicate if the applicant is contracted with all Blue Cross Commercial plans. If not, which Blue Cross plans does the applicant not contract with?

The Ambulatory Surgery Centers affiliated with the Tristar Division of HCA are all contracted with all Blue Cross Blue Shield commercial plans including Blue Cross Blue Shield Network S. StoneCrest Surgery Center will be contracted with all BCBS commercial plans including BCBS Network S.

20. Section B. Economic Feasibility Item 8 Staffing

The table on page 71 is noted. However, please complete the last column of areawide/statewide average salary and submit.

To be submitted under separate cover.

21. Section B. Contribution to Orderly Development Item 1

Please discuss how many physicians by specialty are expected to have privileges at the ASTC and how many of those will have privileges at the hospital?

Please see revised page 40R attached in response to a prior question. There will be 25 in total. These are existing medical staff. All of them do, and will have, privileges at both the ASTC and the hospital.

22. Section B. Contribution to Orderly Development Item 6 Outstanding Projects

Please provide a brief status update for HCA affiliated outstanding projects.

Attached following this page.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

John Wellborn
Consultant

Outstanding Projects--Listed on HSDA Website					
			Annual Progress Report*		
CON Number	Project Name	Date Approved	Due Date	Date Filed	Expiration Date
CN1411-047	Southern Hills Surgery Center -relocate ASTC	3-25-15 Appealed	7-1-17	N/A	7-1-17 (has been extended due to appeal)
Status: Appeals Hearing Decision favorable on June 2, 2017; land purchased; space planning underway; not yet under construction					
CN1407-032	TriStar Centennial Medical Center - Joint Center & ED	10-22-14 Appealed	12-1-17	1-9-17	12-1-17 (has been extended due to appeal)
Status: Appeals Hearing Decision favorable on May 16, 2016; ER renovation and CT scanner complete; construction underway on additional ORs and beds with completion expected in May 2018.					
CN1612-041	TriStar Skyline Medical Center - move 31 beds to main campus	4-26-17	6-1-18	N/A	6-1-20
Status: Project recently approved; architectural planning underway; construction not started.					
CN1510-047	TriStar Horizon Medical Center - NICU	1-27-16	3-1-17	2-13-17	3-1-19
Status: Construction nearing completion; tentatively scheduled to open in October 2017.					
CN1503-007	Parkridge Medical Center - expansion and additional cath lab	6-24-15	8-1-17	7-19-17	8-1-20
Status: Construction underway and nearing completion; overall project expected to be completed by early 2018.					
CN1611-039	Parkridge West Hospital - change 8 m/s beds to psych	2-22-17	4-1-18	N/A	4-1-20
Status: Project is in the final design phase and is on track for completion prior to the expiration date.					
CN1302-002	Hendersonville Medical Center -add NICU & a bed floor	6-26-13	8-1-17	5-23-17	1-1-18
Status: NICU operational; bed floor in final phase of construction with expected completion in November 2017.					

CN1508-031	TriStar Summit Medical Center Satellite ED Mt. Juliet	11-18-15	1-1-17	11/18/16	1-1-19
Status: Site identified and working with developer on final site plans; working with city planning team to develop final plans for utilities, roadway, lighting, etc. for approval by City of Mt. Juliet; not yet under construction					
CN1610-036	TriStar Maury Regional Behavioral Healthcare - JV to establish new behavioral health hosp	2-22-17	4/1/18	N/A	4-1-20
Status: Project recently approved; architectural planning underway; not yet under construction.					
Example:					
CN 000-000	*OR Addition*	*4-15-16*	*4-15-17*	*4-14-17*	*4-15-18*
Status: Construction began on April 1; opening date unchanged					

* must be filed annually dating from CON issuance.

* Annual Progress Reports – HSDA Rules require that an Annual Progress Report (APR) be submitted each year. The APR is due annually until the Final Project Report (FPR) is submitted (FPR is due within 90 ninety days of the completion and/or implementation of the project). Brief progress status updates are requested as needed. The project remains outstanding until the FPR is received.

Supplemental #1 Additional Info (COPY)

StoneCrest Surgery Center

CN1707-023

DSG Development Support Group

JUL 31 '17 AM8:27

SUPPLEMENTAL #1
July 31, 2017
8:27 am

July 30, 2017

Phillip M. Earhart, HSD Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application #1707-023
StoneCrest Surgery Center

Dear Mr. Earhart:

The applicant's July 28 response to your first supplemental request on the subject project contained several questions whose responses were to be submitted "under separate cover". The letter provides those responses. It also provides some additional information.

The items below are numbered to correspond to your questions that were not addressed in the July 28 responses from the applicant. They are provided in triplicate, with affidavit.

2. Section A, Project Details, Item 5.A Name of Management/Operating Entity

Please provide a website address for Medical Care America, LLC and submit a replacement page 12.

The replacement page 12R omitted from the July 28 first supplemental responses is provided following this page.

6. Section B, Need, (Specific Criteria –ASTC) Item 1. Operating Rooms

d. The StoneCrest Surgery Center surgical room utilization Year Two (CY2021) table on page 30a is noted. Please complete the same type of chart for StoneCrest Medical Center for CY2021.

The Medical Center supplemental table is attached as the second following page.

4219 Hillsboro Road, Suite 203
Nashville, TN 37215

jwdsg@comcast.net

Tel 615.665.2022
Fax 615.665.2042

Supplemental Table: Projected Surgical Room Utilization Year Two (CY 2021)
StoneCrest Medical Center

Surgical Rooms	Projected Cases	Cases/Room	Average Room Minutes Used/Case	Average Turnaround Minutes/Case	Average Total Minutes Per Case	Total Minutes Required for Projected Cases	Schedulable Minutes of Room Capacity*	Utilization % of Schedulable Minutes (120,000 Minutes)	Utilization % of Optimal Utilization OR = 884 PR = 1,867
Operating Rooms (8)	3,570	446	102	44	146	521,720	960,000	54.3%	50.5%
IP	1,438		132	44	176	253,088			
OP	2,132		82	44	126	268,632			
Procedure Rooms (3)	3,506	1,169	32	7	39	137,781	360,000	38.3%	62.6%
IP	349		35	7	42	14,658			
OP	3,157		32	7	39	123,123			
Total Surgical Suite	7,076	643				659,501	1,320,000	50.0%	

** 8 hours X 250 days X 60 minutes per hour = 120,000 Schedulable Minutes = SHP standard for 100% Utilization of a surgical room.*

Note: Case minute data are approximate due to roundings in calculations, and will not total exactly to total required case minutes that are taken from specialty-specific table.

11. Section B, Need, (Specific Criteria –ASTC) Item 6. Access to ASTCS

The table of mileage and drive times between project and major communities is noted. However, is the distance to Antioch of 40 miles accurate? Please clarify.

That typographical error has been corrected on revised page 37R, attached following this page.

13. Section B, Need, (Specific Criteria –ASTC) Item 11 Access to ASTCs

The applicant refers to Attachment C-Need-1.A. to document federally underserved areas in the proposed service area. However, the attachment could not be located in the application. The index in the application refers to the attachment as "B-Need State Health Plan-A." Please clarify.

Attached on the second following page are materials showing the Medically Underserved Areas of Rutherford, Davidson, and Williamson Counties. These include a Federal map showing their location in parts of these three counties.

The designated areas are based on census tracts. The applicant is not able to correlate these census tracts with county or zip code boundaries. However, please note the prior submittal of the scores of zip codes that will account for 94% of the project's total cases. While 83% of the projected case volumes will come from ten zip codes, there are numerous other zip codes in Rutherford, Davidson, and Williamson Counties that will contribute some patients. It is likely that some of them do lie within the designated MUA boundaries, though no firm documentation is available to the applicant at this time.

18. Section B. Economic Feasibility Item 6. C. Capitalization Ratio

Please provide the requested capitalization ratio.

FICA Capitalization Ratio:

Long Term Debt	$31,160,000,000
Debt + Equity	$23,858,000,000
	X 100
Traditional Capitalization Ratio	(130.61)

Although the traditional Capitalization Ratio is negative, this does not accurately reflect the financial standing of HCA Healthcare or its ability to fund this project. This is because the 2006 merger and related transactions were accounted for as a "recapitalization" of HCA, Inc. (now HCA Healthcare, Inc.)--rather than as a "sale". Therefore the company's liabilties currently exceed its assets on its books.

A more accurate and informative calculation, as an alternative capitalization ratio is a follows:

Shares Outstanding at 12/31/16	$370,535,903
Closing Market Price per Share at 12/31/16	$74.02
Market Capitalization	$27,427,067,540
Debt + Equity Using Market Capitalization	$58,587,067,540
Alternate Capitalization Ratio	$0.53

20. Section B. Economic Feasibility Item 8 Staffing

The table on page 71 is noted. However, please complete the last column of areawide/statewide average salary and submit.

Revised page 71R with that information is provided following this page.

Additional Items From the Applicant
(Attached Following This Page)

1. The July 28 first supplemental response provided revised pages 23R and 36R, which are the same table used twice in the application. They showed percentages rounded to two places. Attached after this page are revised pages 23R2 and 36R2, changing that table's percentages to one decimal place, for greater clarity. Also, while the group percentages on the table were correct on July 28, the individual facility percentages were not, due to an error in that column's Excel formula. These have been corrected on pages 23R2 and 36R2.

2. Revised Page Three of the July 28 first supplemental response, with percentages rounded to one place rather than two places, to be consistent with the above revised tables. No other changes.

3. Revised page 43R of the application. A typo (the word "The") is deleted after the sentence referencing the attachment.

4. Revised page 84R, requesting a 30-month period of implementation.

5. The original signed affidavit for the July 28 first supplemental responses, along with the affidavit for this July 30 letter.

Also, we ask that you withdraw from the July 28 first supplemental responses two pages that through a clerical error did not belong in that submittal and were not referenced in it. Both were mistakenly included immediately before page 8 of the response letter. One was a redundant copy of the project's earlier submitted PSA zip code map. The other was a zip code patient origin table from a different CON application, that was taken up mistakenly when assembling the July 28 attachments.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

b. Please clarify how many cases represent operating room and procedure room capacity in the table on page 23.

Please see the revised table on the following page, revised page 23R. In summary, it shows the following:

Utilization of ASTC Surgical Rooms in Project Service Area--2016		
	2016 Percent of Full (100%) Utilization	**2016 Percent of Optimal (100%) Utilization**
Operating Rooms		
All 6 ASTC's	72.8%	103.98%
3 Multispecialty ASTCs	76.9%	109.94%
5 ASTC's Excluding Podiatry ASTC	77.2%	110.35%
Procedure Rooms		
All 6 ASTC's	62.9%	89.8%
3 Multispecialty ASTCs	57.5%	82.1%
5 ASTC's Excluding Podiatry ASTC	62.9%	89.8%

6. Section B, Need, (Specific Criteria –ASTC) Item 1. Operating Rooms

a. It is noted the applicant projects an average of 92 minutes per case in Year Two. Please indicate the reason this is higher than the estimated average time per case standard of 65 minutes.

Thank you for bringing that error to the applicant's attention. The Surgery Center Division has corrected the total case time to 65 minutes based on a 50-minute case time more in line with their experience. Please see the table submitted in response to question 7a below.

b. Please explain the reasons OP cases at StoneCrest Medical Center decreased from 3,648 in 2013 to 2,971 in 2016.

One reason was a loss of surgeons. The busiest urologist on staff relocated to California for family reasons. Two busy general surgeons also moved out of State, along with an ENT with a large case volume. While new surgeons have been recruited it takes time for their practices to become established and to experience significant growth. In addition the hospital has seen cases shifting to surgery centers, for the reasons stated in the application's Need narratives.

250

JUL 31 '17 AM 8:28

SUPPLEMENTAL #1
July 31, 2017
8:27 am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY:

STONECREST SURGERY CENTER

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge.

JAN M. DANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 2, 2018

John K Wellborn
Signature/Title
CONSULTANT

Sworn to and subscribed before me, a Notary Public, this the 28th day of July, 2017, witness my hand at office in the County of DAVIDSON, State of Tennessee.

J. M. D.
NOTARY PUBLIC

My commission expires July 2, 2018.

HF-0043

Revised 7/02

SUPPLEMENTAL #1
July 31, 2017
8:27 am

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY:

STONECREST SURGERY CENTER

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge.

JAN M. STANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 2, 2018

John T. Wellborn
Signature/Title
CONSULTANT

Sworn to and subscribed before me, a Notary Public, this the 31ST day of July, 2017, witness my hand at office in the County of DAVIDSON, State of Tennessee.

Jan M. Stanforth
NOTARY PUBLIC

My commission expires July 2, 2018.

HF-0043

Revised 7/02

Supplemental #2
(COPY)

StoneCrest Surgery Center

CN1707-023

DSG Development Support Group

SUPPLEMENTAL #2
July 31, 2017
12:10 pm

July 31, 2017

Phillip M. Earhart, HSD Examiner
Tennessee Health Services and Development Agency
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, TN 37243

RE: CON Application #1707-023
StoneCrest Surgery Center

Dear Mr. Earhart:

This letter responds to your July 31 second supplemental request for additional information on this application. The items below are numbered to correspond to your questions. They are provided in triplicate, with affidavit.

1. **Section B, Need, Page 23 and pages 36, 52b, and 52c.**

   There appear to be remaining typos in four Rutherford County ZIP codes (32127, 32128, 32129, and 32130) within the application. Please correct and submit replacement pages for 23R2, 36R2, 52CR, and 52b.

   Please see those pages 23R3, 36R3, 52bR, and 52cR2, attached following this page.

2. **Section B, Need, (Specific Criteria –ASTC) Item 1. Operating Rooms**

   The StoneCrest Surgery Center surgical room utilization Year Two (CY2021) table on page 30a is noted. However, the page submitted as 30A in supplemental #1 was not labeled as 30A. Please submit labeled as 30AR.

   Revised page 30aR is attached following the four revised pages referenced above.

4219 Hillsboro Road, Suite 203
Nashville, TN 37215

jwdsg@comcast.net

Tel 615.665.2022
Fax 615.665.2042

3. Economic Feasibility, Item 1 Project Cost Chart

Please remove in line A.9 "IT, telecommunications, etc. in H10" and submit a revised Project Cost Chart.

The requested revised page 56R is attached following this page.

Additional Information From Applicant

Attached after this page, following revised page 56R, are very minor revisions to two tables that were submitted to you on July 28. Both are labeled "Revised 7-31-17" to distinguish them from their July 28 versions that followed pages 8 and 10 of the July 28 response letter.

The first table corrects three typographical errors in the 2014-2016 O.R. and Procedure Room utilization data reported by all multi-specialty and single-specialty ASTC's in the three counties containing the zip code-based project service area. The table responds to your question 10 of the July 28 responses. This is the table showing what percentage of the State Health Plan optimal occupancy standards were met by those facilities in 2016. The corrections slightly increased the group utilization averages.

The second table responds to your question 9a of the July 28 responses. It shows the 2014-2016 percentage changes in cases of multi-specialty and single-specialty surgery center groups, in counties containing the project service area as defined by zip codes. This table has been changed to reflect the minor corrections that have been made in the first table.

Thank you for your assistance. We hope this provides the information needed to accept the application into the next review cycle. If more is needed please email or telephone me so that we can respond in time to be deemed complete.

Respectfully,

John Wellborn

John Wellborn
Consultant

Supplemental Table: Ambulatory Surgical Center Cases in Counties That Contain the Primary Service Area--2014 to 2016
StoneCrest Surgery Center (Revised 7-31-17)

County	ASTC		2014						2015						2016								
			O.R.s	O.R. Cases	Cases Per O.R.	Proced. Rooms	P.R. Cases	Cases Per P.R.	O.R.s	O.R. Cases	Cases Per O.R.	Proced. Rooms	P.R. Cases	Cases Per P.R.	O.R.s	O.R. Cases	Cases Per O.R.	% O.R. Change 2014-2016	JAR % Utiliz. Of 884 Cases	Proced. Rooms	P.R. Cases	Cases Per P.R.	% P.R. Change 2014-2016	JAR % Utiliz. Of 1,867 Cases
Davidson	Baptist Ambulatory Surgery Center	M	6	5,687	948	1	1,381	1,381	6	5,723	954	1	1,829	1,829	6	5,650	942		106.5%	1	1,960	1,960		105.0%
Davidson	Baptist Plaza Surgicare (dba St. Thomas SC)	M	9	7,635	848	1	459	459	10	7,318	732	2	919	460	9	8,487	943		106.7%	1	282	282		15.1%
Davidson	Centennial Surgery Center	M	6	4,973	829	2	1,801	901	6	6,058	1,010	2	980	490	6	5,216	869		98.3%	2	2,315	1,158		62.0%
Davidson	Northridge Surgery Center	M	5	2,290	458	2	360	180	5	1,766	353	2	538	269	5	2,171	434		49.1%	2	313	157		8.4%
Davidson	Southern Hills Surgery Center	M																						
Davidson	St. Thomas Campus Surgicare	M	6	5,108	851	1	970	970	6	5,963	994	1	1,240	1,240	6	5,973	996		112.6%	1	1,317	1,317		70.5%
Davidson	St. Thomas Outpatient Neurological Center	M	2	3,890	1,945	1	0	0	2	4,500	2,250	1	0	0	2	4,589	2,295		259.6%	1	0	0		0.0%
Davidson	Summit Surgery Center	M	5	4,826	965	1	513	513	5	4,105	821	1	264	264	5	4,983	997		112.7%	1	428	428		22.9%
Davidson	Turner Surgery Center	M																						
Rutherford	Middle Tennessee Ambulatory Surgery Center	M	6	5,609	935	1	666	666	6	5,837	973	1	873	873	6	6,214	1,036		117.2%	1	934	934		50.0%
Rutherford	Physicians Pavilion Surgery Center	M	4	2,272	568	1	551	551	4	1,991	498	1	568	568	4	2,183	546		61.7%	1	694	694		37.2%
Rutherford	Surgicenter of Murfreesboro Medical Clinic	M	3	3,729	1,243	3	5,138	1,713	3	4,034	1,345	3	5,456	1,819	3	4,237	1,412		159.8%	3	6,036	2,012		107.8%
Williamson	Coal Springs Surgery Center	M	5	5,754	1,151	1	2,667	2,667	5	5,448	1,090	2	2,746	1,373	5	5,698	1,140		128.9%	2	3,526	1,763		94.4%
	MULTI-SPECIALTY FACILITY TOTALS		***57***	***51,773***	***908***	***15***	***14,506***	***967***	***58***	***52,743***	***909***	***17***	***15,413***	***907***	***57***	***55,401***	***972***	***7.0%***	***109.9%***	***16***	***17,805***	***1,113***	***22.7%***	***59.6%***
Davidson	American Endoscopy Center (GI)	S	0	0	0	1	541	0	1	557	557	0	0		1	505	505		57.1%	0	0	0		0.0%
Davidson	Associated Endoscopy (GI)	S	0	0	0	3	5,031	1,677	0	0	0	3	5,453	1,818	0	0	0		0.0%	3	5,593	1,864		99.9%
Davidson	Delozier Surgery Center	S	1	426	426	0	0	0	1	457	457	0	0		1	449	449		50.8%	0	0	0		0.0%
Davidson	Digestive Disease Endoscopy Center (GI)	S	0	0	0	4	6,695	1,674	0	0	0	4	6,620	1,655	0	0	0		0.0%	4	6,059	1,515		81.1%
Davidson	Gurley Surgery Center	S	0	0	0	3	239	80	0	0	0	3	246	82	0	0	0		0.0%	3	180	60		3.2%
Davidson	Mid-State Endoscopy Center (GI)	S	0	0	0	3	2,436	812	0	0	0	3	2,621	874	0	0	0		0.0%	3	2,755	918		49.2%
Davidson	Nashville Endo Surgery Center (GI)	S	0	0	0	3	2,870	957	0	0	0	3	3,106	1,035	0	0	0		0.0%	3	3,633	1,211		64.9%
Davidson	Nashville Gastrointestinal Endoscopy (GI)	S	0	0	0	3	2,594	865	0	0	0	3	2,750	917	0	0	0		0.0%	3	2,853	951		50.9%
Davidson	Oral Facial Surgery Center	S	3	1,453	484	0	0	0	3	2,587	862	0	0		3	2,664	888		100.5%	0	0	0		0.0%
Davidson	Premier Orthopedic Surgery Center (Ortho)	S	2	2,543	1,272	0	0	0	2	2,165	1,083	0	0		2	2,029	1,015		114.8%	0	0	0		0.0%
Davidson	Southern Endoscopy Center (GI)	S	0	0	0	3	2,711	904	0	0	0	3	3,356	1,119	0	0	0		0.0%	3	3,154	1,051		56.3%
Davidson	St. Thomas Med. Group Endoscopy Center (GI)	S	0	0	0	2	4,435	2,218	0	0	0	2	3,505	1,753	0	0	0		0.0%	2	3,363	1,682		90.1%
Davidson	Urology Surgery Center	S	3	3,117	1,039	3	3,867	1,289	3	2,436	812	3	3,654	1,216	3	2,820	940		106.3%	3	3,151	1,050		56.3%
Rutherford	Mid-State Endoscopy Center (GI)	S	0	0	0	2	3,209	1,605	0	0	0	2	2,160	1,080	0	0	0		0.0%	2	2,395	1,198		64.1%
Rutherford	Williams Surgery Center (Podiatry)	S	1	67	67	0	0	0	1	56	56	0	0		1	44	44		5.0%	0	0	0		0.0%
Williamson	Crossroads Surgery Center (Pain)	S	0	0	0	2	669	335	0	0	0	2	137	69	0	0	0		0.0%	2	748	374		20.0%
Williamson	Franklin Endoscopy Center (GI)	S	0	0	0	2	2,744	1,372	2	1,028	514	2	2,975	1,488	2	1,283	642		72.6%	2	3,449	1,725		92.4%
	SINGLE-SPECIALTY FACILITY TOTALS		***10***	***7,606***	***761***	***34***	***38,041***	***1,119***	***13***	***9,286***	***714***	***33***	***36,583***	***1,109***	***13***	***9,794***	***753***	***28.8%***	***85.2%***	***33***	***37,333***	***1,131***	***-1.9%***	***60.6%***
	THREE-COUNTY TOTALS		***67***	***59,379***	***886***	***49***	***52,547***	***1,072***	***71***	***62,029***	***874***	***50***	***51,996***	***1,040***	***70***	***65,195***	***931***	***9.8%***	***105.4%***	***49***	***55,138***	***1,125***	***4.9%***	***60.3%***

Source: Joint Annual Reports 2014-2016.

Note: Excludes single-specialty facilities performing surgery types not projected for StoneCrest Surgery Center (e.g. pain, ophthalmology, etc.)

Supplemental Table--ASTC Utilization by Room Type In Counties That Contain the Primary Service Area StoneCrest Surgery Center (Revised 7-31-17)				
Multi-Specialty ASTC's	**2014**	**2015**	**2016**	**% Change 2014-16**
Operating Rooms	57	58	57	0.0%
Cases	51,773	52,743	55,401	7.0%
Cases per O.R.	908	909	972	7.0%
Procedure Rooms	15	17	16	6.7%
Cases	14,506	15,413	17,805	22.7%
Cases per PR	967	907	1,113	15.1%
Single-Specialty ASTC's	**2014**	**2015**	**2016**	**% Change 2014-16**
Operating Rooms	10	13	13	30.0%
Cases	7,606	9,286	9,794	28.8%
Cases per O.R.	761	714	753	-0.9%
Procedure Rooms	33	33	33	0.0%
Cases	37,500	36,583	37,333	-0.4%
Cases per PR	1,136	1,109	1,131	-0.4%

Source: JARs 2014-2016

257

JUL 31 '17 PM2:05

SUPPLEMENTAL #2
July 31, 2017
12:10 pm

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF DAVIDSON

NAME OF FACILITY:

Stonecrest Surgery Center

I, JOHN WELLBORN, after first being duly sworn, state under oath that I am the lawful agent of the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete to the best of my knowledge.

JAN M. DANFORTH
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires July 2, 2018

John Wellborn
Signature/Title
CONSULTANT

Sworn to and subscribed before me, a Notary Public, this the 31st day of July, 2017, witness my hand at office in the County of DAVIDSON, State of Tennessee.

J. M. Danforth
NOTARY PUBLIC

My commission expires July 2, 2018.

HF-0043